Dermatological History Taking – OSCE Guide

Taking a **dermatological history** is an important skill that is often assessed in OSCEs. This guide provides a structured approach to taking a history of a skin lesion or rash in an OSCE setting.

Download the dermatological history taking PDF OSCE checklist, or use our interactive OSCE checklist. You may also be interested in our other dermatology guides.

Introduction

Wash your hands and **don PPE** if appropriate.

Introduce yourself to the patient including your **name** and **role**.

Confirm the patient's **name** and **date of birth**.

Explain that you'd like to take a history from the patient.

Gain consent to proceed with history taking.

General communication skills

It is important you do not forget the **general communication skills** which are relevant to all patient encounters. Demonstrating these skills will ensure your consultation remains patient-centred and not checklist-like (just because you're running through a checklist in your head doesn't mean this has to be obvious to the patient).

Some **general communication skills** which apply to all patient consultations include:

- Demonstrating empathy in response to patient cues: both verbal and non-verbal.
- Active listening: through body language and your verbal responses to what the patient has said.
- An appropriate level of eye contact throughout the consultation.
- Open, relaxed, yet professional body language (e.g. uncrossed legs and arms, leaning slightly forward in the chair).
- Making sure not to interrupt the patient throughout the consultation.
- Establishing rapport (e.g. asking the patient how they are and offering them a seat).
- Signposting: this involves explaining to the patient what you have discussed so far and what you plan to discuss next.
- Summarising at regular intervals.

Presenting complaint

Use **open questioning** to explore the patient's **presenting complaint**:

- *"What's brought you in to see me today?"*
- *"Tell me about the issues you've been experiencing."*

Provide the patient with enough **time** to answer and avoid interrupting them.

Facilitate the patient to **expand** on their **presenting complaint** if required:

> *"Ok, can you tell me more about that?"*

Open vs closed questions

History taking typically involves a combination of **open** and **closed questions**. Open questions are effective at the start of consultations, allowing the patient to tell you what has happened in their own words. Closed questions can allow you to explore the symptoms mentioned by the patient in more detail to gain a better understanding of their presentation. Closed questions can also be used to identify relevant risk factors and narrow the differential diagnosis.

History of presenting complaint

Patients with rashes and skin lesions can present with a wide variety of associated symptoms which we've summarised below.

Key dermatological symptoms

Key **dermatological symptoms** include:

- Rash
- Skin lesion
- Pain
- Itch
- Bleeding
- Discharge
- Blistering
- Systemic symptoms: fever, malaise, weight loss and arthralgia.

SOCRATES

The **SOCRATES** acronym is a useful tool for exploring each of the patient's presenting symptoms in more detail. It is most commonly used to explore pain, but it can be applied to other symptoms, although some of the elements of SOCRATES may not be relevant to all symptoms.

Site

Ask about the **location** of the symptom:

> *"Where is the skin lesion?"*

Onset

Clarify **how** and **when** the symptom developed:

> *"When did you first notice the skin lesion?"*

Character

Ask about the **specific characteristics** of the symptom:

- *"How does the skin lesion feel when you touch it?"*
- *"How many of the skin lesions are there?"*
- *"What shape are the skin lesions?"*

Radiation

Ask if the symptom **moves anywhere** else:

> *"Does the pain spread anywhere else?"*

Associated symptoms

Ask if there are other symptoms which are **associated** with the primary symptom:

- *"Are there any other symptoms that seem associated with the rash?"*
- *"Have you noticed the skin lesion itching or bleeding?"*

Time course

Clarify how the symptom has **changed** over **time**:

- *"How has the rash changed over time?"*
- *"How has the skin lesion changed over time?"*
- *"Have you had a rash like this in the past?"*

Exacerbating or relieving factors

Ask if anything makes the symptom **worse** or **better**:

- *"Does anything seem to make the rash worse?"*
- *"Does anything make the rash better?"*

Severity

Assess the **severity** of the symptom by asking the patient to grade it on a scale of 0-10:

> *"On a scale of 0-10, how severe is the pain, if 0 is no pain and 10 is the worst pain you've ever experienced?"*

Treatments

Ask the patient if they have tried any **treatments** for the problem already:

- *“Have you tried any treatments for your rash?”*
- *“Did they make any difference?”*

Previous episodes

Ask the patient if they have **previously** experienced **similar episodes** of the problem:

- *“Have you ever had a rash like this in the past?”*
- *“What happened the last time?”*

Ask the patient if they tried any **treatments** for the **previous episode**:

- *“Did you try any creams or tablets to treat the problem last time?”*
- *“Did the treatment work?”*

Contact history

Clarify if the patient has recently had any contact with **infectious diseases** (e.g. chickenpox):

> *“Have you been in contact with anyone recently who had an infectious disease or skin problems like yours?”*

Ideas, concerns and expectations

A key component of history taking involves exploring a patient’s **ideas**, **concerns** and **expectations** (often referred to as **ICE**) to gain insight into how a patient currently perceives their situation, what they are worried about and what they expect from the consultation.

The exploration of ideas, concerns and expectations should be **fluid** throughout the consultation in **response to patient cues**. This will help ensure your consultation is more **natural**, **patient-centred** and not overly formulaic.

It can be challenging to use the ICE structure in a way that sounds natural in your consultation, but we have provided several examples for each of the three areas below.

Ideas

Explore the patient’s **ideas** about the current issue:

- *“What do you think the problem is?”*
- *“What are your thoughts about what is happening?”*
- *“It’s clear that you’ve given this a lot of thought and it would be helpful to hear what you think might be going on.”*

Concerns

Explore the patient’s current **concerns**:

- *“Is there anything, in particular, that’s worrying you?”*
- *“What’s your number one concern regarding this problem at the moment?”*
- *“What’s the worst thing you were thinking it might be?”*

Expectations

Ask what the patient hopes to **gain** from the consultation:

- *“What were you hoping I’d be able to do for you today?”*
- *“What would ideally need to happen for you to feel today’s consultation was a success?”*
- *“What do you think might be the best plan of action?”*

Summarising

Summarise what the patient has told you about their **presenting complaint**. This allows you to **check your understanding** of the patient’s history and provides an opportunity for the patient to **correct** any **inaccurate information**.

Once you have **summarised**, ask the patient if there’s anything else that you’ve **overlooked**. Continue to **periodically summarise** as you move through the rest of the history.

Signposting

Signposting, in a history taking context, involves explicitly stating **what you have discussed so far** and **what you plan to discuss next**. Signposting can be a useful tool when **transitioning** between different parts of the patient’s history and it provides the patient with time to **prepare** for what is coming next.

Signposting examples

Explain what you have covered so far: *“Ok, so we’ve talked about your symptoms, your concerns and what you’re hoping we achieve today.”*

What you plan to cover next: *“Next I’d like to discuss your past medical history and then explore what medications you currently take.”*

Systemic enquiry

A **systemic enquiry** involves performing a brief screen for symptoms in other body systems which may or may not be relevant to the primary presenting complaint. A systemic enquiry may also identify symptoms that the patient has forgotten to mention in the presenting complaint.

Deciding on which symptoms to ask about depends on the presenting complaint and your level of experience.

Some examples of **symptoms** you could **screen for** in each **system** include:

- **Systemic**: fevers (e.g. cellulitis)
- **Cardiovascular**: peripheral oedema
- **Respiratory**: wheeze, dyspnoea (e.g. anaphylaxis)
- **Gastrointestinal**: abdominal pain and diarrhoea (e.g. Crohn's disease)
- **Neurological**: confusion (e.g. meningococcal sepsis)

Travel history

Ask the patient if they have recently been **travelling** and consider if this may have relevance to their presenting complaint (e.g. erythema migrans after visiting a location with potential tick exposure).

Past medical history

Ask if the patient has any **medical conditions**:

- *"Do you have any medical conditions?"*
- *"Are you currently seeing a doctor or specialist regularly?"*

If the patient does have a medical condition, you should gather more details to assess **how well controlled** the disease is and what **treatment(s)** the patient is receiving. It is also important to ask about any **complications** associated with the condition including **hospital admissions**.

Ask if the patient has previously undergone any **surgery** or **procedures** (e.g. excision of skin lesion):

- *"Have you ever previously undergone any operations or procedures?"*
- *"When was the operation/procedure and why was it performed?"*

Sun exposure

Assess the patient's previous **sun exposure** (including sunbed use) to determine skin cancer risk.

Ask the patient how their skin **reacts** to sun exposure to help determine their skin type using the **Fitzpatrick scale**.

Ask if the patient's symptoms seem to **worsen** (e.g. systemic lupus erythematosus) or **improve** (e.g. psoriasis) after sun exposure.

Allergies

Ask if the patient has any **allergies** and if so, clarify **what kind of reaction** they had to the substance (e.g. mild rash vs anaphylaxis).

Examples of relevant medical conditions

Medical conditions relevant to **dermatological disease** include:

- Previous skin cancer or other dermatological conditions
- Atopy
- Diabetes (e.g. acanthosis nigricans, scleroderma diabeticorum, necrobiosis lipodica)
- Inflammatory bowel disease (e.g. pyoderma gangrenosum, erythema nodosum)
- Other medical conditions requiring systemic immunosuppression (increased risk of skin cancer)

Drug history

Ask if the patient is currently taking any **prescribed medications** or **over-the-counter remedies**:

> *"Are you currently taking any prescribed medications or over-the-counter treatments?"*

If the patient is taking prescribed or over the counter medications, **document** the **medication name**, **dose**, **frequency**, **form** and **route**.

Ask the patient if they're currently experiencing any **side effects** from their medication:

> *"Have you noticed any side effects from the medication you currently take?"*

Medication examples

Medications **prescribed** to patients with dermatological disease include:

- Emollients
- Ointments
- Topics steroids
- Antibiotics
- Systemic immunosuppressants (e.g. biologics)

Relevant **over the counter purchases** which may cause or worsen dermatological symptoms:

- Skincare products
- Soaps
- Cosmetics

Family history

Ask the patient if there is any **family history** of dermatological disease:

> *"Do any of your parents or siblings have any skin problems?"*

Clarify at what **age** the disease **developed** (disease developing at a younger age is more likely to be associated with genetic factors):

> *"At what age did your father develop melanoma?"*

Social history

Explore the patient's **social history** to both understand their **social context** and identify potential **dermatological risk factors**.

General social context

Explore the patient's **general social context** including:

- the type of accommodation they currently reside in (e.g. house, bungalow) and if there are any adaptations to assist them (e.g. stairlift)
- who else the patient lives with and their personal support network
- what tasks they are able to carry out independently and what they require assistance with (e.g. self-hygiene, housework, food shopping)
- if they have any carer input (e.g. twice daily carer visits)
- if they have recently changed any cleaning products which coincide with the development of their symptoms

Smoking

Record the patient's **smoking history**, including the type and amount of tobacco used.

Smoking is a risk factor for skin cancer and significantly impacts general skin health.

Alcohol

Record the **frequency**, **type** and **volume** of **alcohol** consumed on a weekly basis.

Recreational drug use

Ask the patient if they use **recreational drugs** and if so determine the type of drugs used and their frequency of use.

Intravenous drug use is associated with an increased risk of cellulitis and necrotising fasciitis at injection sites. Intravenous drug users are also more likely to be infected by HIV and hepatitis B/C, all of which can present with dermatological manifestations.

Diet

Ask if the patient has recently changed their **diet** or noticed that certain food types seem to trigger their symptoms (e.g. rash associated with coeliac disease).

Occupation

Ask about the patient's current **occupation** to clarify what their job role involves.

Ask if the patient's skin problems seem to be worse when they're working and if the problems improve when they have some time off.

Clarify if the patient is exposed to any skin irritants or other hazardous substances in their work.

Closing the consultation

Summarise the **key points** back to the patient.

Ask the patient if they have any **questions** or **concerns** that have not been addressed.

Thank the patient for their time.

Dispose of PPE appropriately and **wash your hands**.