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Using outcomes-based methodology for the education, training and assessment of competence of healthcare professionals

Figure 4: Occupational standard for taking an ophthalmic patient history

Title

Obtain ophthalmic patient history to assist with diagnosis and treatment planning

Range indicators

This standard relates to the taking of an ophthalmic clinical history from adult and paediatric patients, their relatives and carers, prior to examination and treatment

Performance Criteria

You must be able to:

- a. Obtain history consistent with personal role, responsibilities and level of competence
- b. Confirm patient Identification / details
- c. Confirm patient's consent prior to commencing history taking
- d. Identify any special needs related to communication or comprehension and take appropriate action
- e. Explain to the patient and/or patient representative the purpose of history taking and confidentiality of information obtained
- f. Obtain and record a history of patient's presenting ocular and/or visual symptoms
- g. Obtain and record a history of patient's past ocular diseases and conditions, including history of surgery to eye or ocular adnexae, and details of birth history where appropriate
- h. Obtain and record a family history of diseases affecting eye or vision, and any relevant general medical conditions or diseases
- i. Obtain and record details of social history including occupation and details of exposure to industrial or occupational hazards
- j. Obtain and record a history of patient's current and past general health and trauma, including any surgical procedures
- k. Obtain and record a history of current medications for ocular conditions and general medical conditions
- l. Obtain and record a history of any allergies or other adverse reactions to treatments
- m. Identify aspects or areas of particular concern and inform relevant professional if appropriate

You must know and understand:

- Personal role, responsibilities and level of competence for procedure
- Requirements for confidentiality of information
- Requirements for accurate and legible recording of information
- The purpose and relevant protocols for obtaining and documenting patient history
- The anxieties or concerns which patients, parents or carers may experience and how to alleviate them
- How to communicate effectively with patients, parents or carers including patients with a range of special needs
- The relevance of patient history to ocular and systemic disease
- The symptoms of common diseases affecting the visual system and the relationship between ocular/visual and non-ocular symptoms and diseases of the visual system and systemic disease
- Ocular/visual manifestations of systemic disease