Instructions to the Candidate:

- **Review** the patient information and present a focused history-taking approach.
- **Formulate** an initial differential diagnosis and discuss the necessary investigations.
- **Outline** an appropriate management plan, including education and safety measures.
- **You have 15 minutes** for this clinical encounter.

Patient Record Summary:

- **Name:** Peter Reynolds
- **Age:** 38 years
- **Gender:** Male
- **Indigenous Status:** Not Aboriginal or Torres Strait Islander
- **Allergies and Adverse Reactions:** Nil known
- **Medications:** None.
- **Past Medical History:**
    - Previously healthy, with no chronic conditions.
- **Social History:**
    - Works as a project manager in construction.
    - Non-smoker, occasional alcohol use.
    - Enjoys hiking but has felt too fatigued to participate over the past few months.
- **Family History:**
    - Father: Type 2 diabetes.
    - Mother: Rheumatoid arthritis.

Scenario:

Peter Reynolds, a 38-year-old project manager, presents with a 3-month history of **progressive fatigue**, **unintentional weight loss** (approximately 5 kg), and **occasional nausea**. He reports feeling lightheaded when standing up.

Peter denies recent infections, trauma, or significant stressors beyond his usual job pressures. He has not experienced abdominal pain, but he does mention that he often feels weak and struggles with maintaining energy levels throughout the day.

Clinical Examination Findings:

- **General Appearance:** Appears tired, cooperative.
- **Vital Signs:**
    - BP: 98/62 mmHg (drops to 85/55 mmHg on standing)
    - HR: 88 bpm, regular
    - Temp: 36.5°C
    - RR: 14/min
    - SpO2: 98% on room air
- **Physical Examination:**
    - Hyperpigmentation noted on the knuckles and oral mucosa.
    - No goiter or thyroid nodules.
    - Abdomen soft, non-tender with no organomegaly.
