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CASE CHIEF COMPLAINT: *(does not include actual diagnosis)*	
CASE NAME:	
CASE NUMBER: *(assigned by GCPC)*	
PRESENTING SITUATION: *(write a few sentences about the patients' presenting problem)*	
KEYWORD DESCRIPTIONS: *(describe the patient's problem, parent disciplines, focus of the case, e.g. health risk appraisal, and other key words that characterize the case and the assessment challenge)*	
DIFFERENTIAL DIAGNOSIS*: (list competing diagnostic possibilities)*	
ACTUAL DIAGNOSIS:	
DESIGNED FOR*: (list what level of student this examination is designed for, i.e. 2nd year medical student; residents)*	
ACTIVITIES & TIME REQUIRED*: (determine how much time is needed for each student to interview and examine the patient and how much time will be given for the post-encounter exercise. We have found that 15 minutes is enough time to capture student performance. If you have several cases in an examination, it is best to time each station the same, e.g. A 15 minute patient encounter followed by a 10 minute post-encounter exercise.)*	
OBJECTIVES: *(list learner objectives to be assessed or taught through use of this case, eg: 1) Development of data base, 2) Detection of findings 3) Time efficiency, 4) Interview and physical examination skills)*	
STATION REQUIREMENTS: *(list what is supplies and/or equipment is needed for this station, including patient and student paperwork)*	
ASPECT OF PERFORMANCE TO BE ATTENDED TO & METHOD FOR	

OBSERVING PERFORMANCE*:* *(list instruments, and attach data collection checklist, professional behavior rating scale, and the post-encounter questionnaire regarding findings, diagnostic conclusions, initial management plan, etc., at the end of the template.)*	
FOR MORE INFORMATION ABOUT THIS CASE: *(supply name, address and phone number of the physician and case developer who designed the case)*	

SUMMARY OF CASE	
PROVIDE A SUMMARY OF THE CASE INCLUDING PRESENTING PROBLEM, LOCATION OF ENCOUNTER, STUDENT'S TASK**:**	
STANDARDIZED PATIENT RECRUITMENT REQUIREMENTS	
DEMOGRAPHIC INFO (of SP to be recruited, not of patient):	<table><tr><td>Gender:</td><td></td></tr><tr><td>Age:</td><td></td></tr><tr><td>Race:</td><td></td></tr><tr><td>Height:</td><td></td></tr><tr><td>Weight:</td><td></td></tr><tr><td>Other: (*eg language*)</td><td></td></tr></table>
INCOMPATIBLE PATIENT CHARACTERISTICS: *(i.e., someone with abdominal scars, hysterectomy scar, heart problems, etc.)*	

LEARNER INSTRUCTIONS

PATIENT:

AGE:

CHIEF COMPLAINT:

SETTING:

TIME OF DAY:

VITAL SIGNS:
Blood Pressure:
Pulse:
Respiration:
Temperature:

LEARNER TASK: List the student's task for this station. If at all possible, it is best not to have the examinee pretend to be something other than what he/she is.

Example:

You are a 2nd year medical student. You have 15 minutes to:

1. *Obtain an appropriate history*
2. *Perform a pertinent physical examination*
3. *Give your tentative diagnostic impressions to the patient:*

When you have completed your interview, you will be given 10 minutes to document your findings.

STANDARDIZED PATIENT TRAINING MATERIALS

OVERVIEW	**NAME :**
Objective	Portray a patient with . . .
Patient Description	<table><tr><td>Gender:</td><td></td></tr><tr><td>Age:</td><td></td></tr><tr><td>Race:</td><td></td></tr><tr><td>Height:</td><td></td></tr><tr><td>Weight and/or BMI:</td><td></td></tr><tr><td>Socioeconomic:</td><td></td></tr><tr><td>Orientation:</td><td></td></tr><tr><td>Marital Status:</td><td></td></tr><tr><td>If single, do you live alone?</td><td></td></tr><tr><td>If married, how many years?</td><td></td></tr><tr><td>Children:</td><td></td></tr><tr><td>Grandchildren:</td><td></td></tr><tr><td>Address:</td><td></td></tr><tr><td>Own or rent:</td><td></td></tr><tr><td>Occupation:</td><td></td></tr><tr><td>Duties at work:</td><td></td></tr><tr><td>Spouse's occupation:</td><td></td></tr><tr><td>Hobbies/Interests:</td><td></td></tr><tr><td>Military History:</td><td></td></tr><tr><td>Self Presentation/Appearance:</td><td></td></tr></table>
Patient affect	*[anxious, angry, etc]*
Opening Statement	**"I'm here today because . . ."**
Any information that must be provided, even if not elicited? When? (*e.g., by 5 minutes into encounter*)	
Information to be volunteered in response to an open question, vs. Elicited information:	*(Once student asks a closed question, patient does not volunteer information until next asked an open question.)*
After first open question:	
After additional open question:	
Any questions that patient should ask of student? When?	

<table>
<tr><td>Any patient statements/actions that provide opportunities for empathic reflection by the student?</td><td></td></tr>
<tr><td>Should patient respond differently to different types of students?</td><td>Yes? No?<table><tr><td>Empathic:</td><td></td></tr><tr><td>Unempathic:</td><td></td></tr><tr><td>Other:</td><td></td></tr></table></td></tr>
<tr><td>Other encounter guidelines:</td><td></td></tr>
</table>

HISTORY OF THE PRESENT ILLNESS	
PHYSICAL SYMPTOMS	
Chief Complaint/Reason for Visit or Admission:	
Onset:	
Duration:	
Location:	
Character:	
Radiation:	
Intensity: *(scale of 1-10)*	
Aggravating Factors:	
Alleviating Factors:	
Pattern:	
Course: *(getting better or worse?)*	
Context: *(what was the setting/context of onset?)*	
Associated Symptoms:	
Response to Symptoms: *(what has the patient done about the symptoms other than seeking health care?)*	
Consequences: *(what to the symptoms interfere with?)*	
Meaning of the illness: *(patient's ideas, feelings, fears about the causes/implications)*	

PATIENT'S PAST MEDICAL HISTORY	
Overall Health:	
Childhood Illnesses:	
Adult Illnesses:	
Immunizations: *(e.g. tetanus, DPT, MMR, etc. Give dates of latest immunizations.)*	
Hospitalizations:	
Surgical Procedures:	
Injuries/Traumas:	
Transfusions:	
Allergies/Drug Reactions:	
Current Medications:	

Over-the-counter:	
Prescriptions:	

Psychiatric History:

Depression:	
Thoughts of suicide:	
Thoughts of harming others:	
Anxiety:	
PTSD:	
Mental health treatment:	
Mental health hospitalization:	

Gynecological History:

Start of Menses:	
Cycle:	
Duration of menses each month:	
Flow:	
Last period:	
Last gynecological exam:	
Last PAP and results:	
Any abnormal PAPs in past:	
Any pregnancies:	
Any miscarriages:	
If menopausal:	
Age it began:	
Taking estrogen?	

Disease Detection/Prevention:

	Yes/No	When:	Results:
Visits physician regularly:			
Cholesterol checked:			
TB Test			
Performs self breast/testicular exam			

	Visits dentist			
	Visits ophthalmologist			

Lifestyle/Behavioral Risks:

Eating Habits:	
Exercise:	
Sleeping Habits:	
Stress:	
Tobacco:	
Alcohol:	
Illicit Drugs:	

Sexual Habits:

Current:

Monogamous:	
Number of partners:	
Orientation:	
Form of birth control:	
Safe sex practices:	

Past:

Monogamous:	
Number of partners:	
Orientation:	
Form of birth control:	
Safe sex practices:	

History of STDs:	
Tested for AIDS:	

FAMILY MEDICAL HISTORY

Mother:	
Father:	
Sister(s):	
Brother(s):	
Grandparents(s):	
Spouse's Health:	

<table>
<tr><td>PHYSICAL EXAM</td><td>Consists of: (descriptions of specific physical exam related to complaint)
<table>
<tr><td>PE maneuver (eg, palpate abdomen)</td><td>PE finding (eg,tender to deep palpation in RUQ)</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Labs: (Attach at end if any)</td><td>
<table>
<tr><td>Any pelvic/rectal results?</td><td></td></tr>
<tr><td>Any lab results?</td><td></td></tr>
<tr><td>Any X-rays or MRIs?</td><td></td></tr>
</table></td></tr>
<tr><td>SPECIAL INSTRUCTIONS</td><td></td></tr>
</table>

REVIEW OF SYSTEMS	*List any medical problems or findings the patient has that are important to the case. Only list those problems or findings that relate to the chief complaint at hand.*
GENERAL:	*(e.g. weakness, fatigue, weight change, appetite, sleeping habits, chills, fever, night sweats)*
SKIN:	*(e.g. rashes, lesions, easy bruising, pruritus, lumps, color change, hair or nail changes)*
EYES:	*(e.g. acuity, eyeglasses, contacts, photophobia, blurring, diplopia, spots, discharge, floaters, glaucoma, cataracts)*
EARS:	*(e.g. hearing changes, tinnitus, discharge, pain, vertigo)*
NOSE, THROAT, SINUSES:	*(e.g. congestion, hay fever, polyps, epistaxis, trauma)*
MOUTH OR ORAL CAVITY:	*(e.g. painful teeth or gums, last dentist visit, sore tongue, sore throat, hoarseness)*
BREASTS:	*(e.g. lumps, pain, discharge, self exam, mammogram)*
RESPIRATORY:	*(e.g. chest pain, cough, sputum – color, quality, quantity, hemoptysis, pneumonia, TB, SOB)*
CARDIOVASCULAR:	*(e.g. pain, hypertension, SOB, orthopnea, exercise intolerance, prior heart trouble (MI), PND, murmurs, leg cramps, swollen ankles, former EKGs, stress test, other tests)*
PERIPHERAL VASCULAR:	*(e.g. varicosities, thrombophlebitis, cramps, claudication, finger pallor or cyanosis)*
GASTROINTESTINAL:	*(e.g. dysphagia, food intolerance, hematemesis, bloating, dyspepsia, frequent belching, ulcer, nausea, vomiting, early satiety, bowel habits, stool character, stool color, blood per rectum, hemorrhoids, jaundice, liver ds, gall bladder ds)*
HEMATOPOIETIC:	*(e.g. anemia, bruising, bleeding, transfusions, swollen glands)*
URINARY TRACT:	*(e.g. difficulty in urination [dysuria], frequency, hesitancy, urgency, nocturia, polyuria, infections, incontinence, pyuria, hematuria, stones)*
MALE REPRODUCTIVE:	*(e.g. penile discharge, lesions, hermias, testicular pain, testicular mass, infertility, impotence, libido)*
FEMALE REPRODUCTIVE:	*(e.g. gravida/para: full term, pre-term, abortions, live children. Age of menarche, last menstrual period, frequency, duration, quantity of flow, dysmenorrhea. Age at menopause, symptoms of menopause. Contraception, last pelvic exam, last PAP test, dyspareunia)*
MUSCULOSKELETAL:	*(e.g. joint pain, stiffness, swelling, arthritis, gout, backache, muscle pain or stiffness, scoliosis, how much exercise)*
ENDOCRINE:	*(e.g. thyroid trouble, goiter, heat or cold intolerance, excessive sweating, polyuria, polydypsia, polyphagia, hair/nail texture)*
CENTRAL NERVOUS SYSTEM:	*(e.g. fainting, blackouts, headaches, seizures, local weakness, numbness, tremors, coordination, memory or attention deficits)*
PSYCHIATRIC:	*(e.g. depression, anxiety, tension, recent loss, thought disorders, drug and/or alcohol problems, hospitalizations, level of functioning)*

CHECKLIST

Max 15 items, not counting standard communication rating scale

	Student Action	SP response	Rating Options
	[e.g "where does it hurt?"]	*[Points to LUQ]*	*[e.g. done/not done]*
	[e.g. palpated abdomen in four quadrants] *PE maneuvers should follow HTT protocol unless NA*	*[Tender to deep palpation LUQ]*	*[e.g. done correctly, done incorrectly, not done]*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Attachments

Lab values, Xrays, communication scales, etc

Exemplar Note

Faculty: Please write a "gold standard" exemplar note to be used when grading the student's note. Please highlight the key positive and negative findings. Note – you must follow the template below, which is formatted per the USMLE Step 2 CS.

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1. ***History: "****Describe the history you just obtained from this patient. Include only pertinent positives and negatives relevant to this patient's problem. Include CC and HPI that incorporates any relevant aspects of patient's medical history."*

2. ***Physical Exam:*** *"Describe any pertinent positive or negative PE findings that you elicited relevant to this patient's problems. Include VS from the chart."*

3. ***Data Interpretation****: "Based on what you have learned from the history and PE, list up to 3 diagnoses that might explain this patient's complaints. Do not list diagnoses that you have already ruled out. List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate. Then, enter the positive and negative findings from the history and PE (if present) that support each diagnosis. Do not include what you would or should have done if you forgot to do it, nor include something you did not do. There is no need to list history and PE findings that help refute a diagnosis."*

Diagnosis 1: _____

History Findings:

PE Findings:

Diagnosis 2: _____

History Findings:

PE Findings:

Diagnosis 3: _____

History Findings:

PE Findings:

4. *Diagnostic Studies: "List initial diagnostic studies (if any) you would order for this patient. Max 5."*