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CASE CHIEF COMPLAINT: *(does not include actual diagnosis)*	Sneezing and coughing
CASE NAME:	Pat Jones
CASE NUMBER: *(assigned by GCPC)*	SP AUDITIONS CASE 1
PRESENTING SITUATION: *(write a few sentences about the patients' presenting problem)*	Patient comes to clinic due to sneezing and coughing
ACTUAL DIAGNOSIS:	Allergies to Cats
DESIGNED FOR*: (list what level of student this examination is designed for, i.e. 2nd year medical student; residents)*	SP Hiring Process
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.)*	Prospective SPs will participate in two mock encounters with staff at the GCPC. Each encounter will be 10 minutes in length with debriefing with the staff member at the end of each encounter.
STATION REQUIREMENTS: *(list what is supplies and/or equipment is needed for this station, including patient and student paperwork)*	SP exam rooms, checklists

SUMMARY OF CASE

PROVIDE A SUMMARY OF THE CASE INCLUDING PRESENTING PROBLEM, LOCATION OF ENCOUNTER, STUDENT'S TASK**:**	Pat Jones comes into the clinic complaining of sneezing and coughing, symptoms that don't seem to be going away. He/she is concerned about the flu.

STANDARDIZED PATIENT RECRUITMENT REQUIREMENTS

DEMOGRAPHIC INFO (of SP to be recruited, not of patient):

Gender:	Use own
Age:	Use own age
Race:	N/A
Height:	N/A
Weight:	N/A

LEARNER INSTRUCTIONS

PATIENT: **Pat Jones**

AGE:

CHIEF COMPLAINT: **Cough and Sneezing**

VITAL SIGNS:

Blood Pressure:	120/80
Pulse:	72
Respiration:	16
Temperature:	98.6

SETTING: **Clinic**

LEARNER TASK:

You are a 4th 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:*

STANDARDIZED PATIENT TRAINING MATERIALS

OVERVIEW	**NAME : Pat Jones**
Objective	
Patient Description	

Gender:	Use own
Age:	Use Own
Race:	Use own
Height:	Use own
Weight and/or BMI:	Use own
Socioeconomic:	Middle
Orientation:	Heterosexual
Marital Status:	Single
If single, do you live alone?	Has a roommate
If married, how many years?	
Children:	No
Grandchildren:	No
Address:	5132 N. Ashland
Own or rent:	Rent
Occupation:	Teacher
Duties at work:	
Spouse's occupation:	
Hobbies/Interests:	
Military History:	
Self Presentation/Appearance:	

Patient affect	Calm, agreeable.
Opening Statement	**"I'm here today because I have recently developed a cough and am sneezing a lot. I thought it was just a cold but it doesn't seem to be going away. I have had it for 2 weeks.** (If student interrupts your opening statement, stop and only answer questions asked from that point forward.)
Any information that must be provided, even if not elicited? When? (*e.g., by 5 minutes into encounter*)	- Just got a cat. It sleeps with me every night– (must be said at 5 minute warning if student has not elicited this information)
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.)* N/A
After first open question:	Nothing
After additional open question:	Nothing
Any questions that patient should ask of student? When?	Can I get a second opinion? (at end of encounter)

HISTORY OF THE PRESENT ILLNESS	
PHYSICAL SYMPTOMS	
Chief Complaint/Reason for Visit or Admission:	Cough and sneezing
Onset:	Sneezing started 2 weeks ago. Cough began 1 week ago
Duration:	Intermittent
Location:	NA
Character:	N/A
Radiation:	N/A
Intensity: *(scale of 1-10)*	N/A
Aggravating Factors:	Worse at home. Also worse at night and morning
Alleviating Factors:	Leaving home. Benadryl that roommate gave me
Pattern:	Worse at night and morning.
Course: *(getting better or worse?)*	Sneezing started 2 weeks ago. Cough began 1 week ago. Both seem to be getting worse
Context: *(what was the setting/context of onset?)*	(only if asked specifically about pets in house and/or anything new in patient's life) a week after got new cat.
Associated Symptoms:	Itchy eyes for two weeks, trouble breathing started 3 days ago. (If student follows up: the trouble breathing it is only in the morning.)
Response to Symptoms: *(what has the patient done about the symptoms other than seeking health care?)*	Took Benadryl (not sure what it does-roommate gave it to me) and came to see a doctor.
Consequences: *(what to the symptoms interfere with?)*	Not sleeping well
Meaning of the illness: *(patient's ideas, feelings, fears about the causes/implications)*	I have been worried I am getting the flu. I have been reading a lot about it in the news

PATIENT'S PAST MEDICAL HISTORY	
Overall Health:	
Childhood Illnesses:	Asthma (If asked: you grew out of it, and your last attack was around 16 y/o)
Adult Illnesses:	None
Immunizations: *(e.g. tetanus, DPT, MMR, etc. Give dates of latest immunizations.)*	Up to date
Hospitalizations:	None
Surgical Procedures:	None
Injuries/Traumas:	Broke left arm in rollerblading accident at age 17
Transfusions:	none

Allergies/Drug Reactions:	none
Current Medications:	

Over-the-counter:	None-though took some Benadryl roommate gave me
Prescriptions:	none

Disease Detection/Prevention:

	Yes/No	When:	Results:
Visits physician regularly:	Yes	6 months ago	healthy
Cholesterol checked:	Yes	6 months ago	180
TB Test	Yes	in last 3 yrs	
Performs self breast/testicular exam	No	No	
Visits dentist	Yes	1 year ago	
Visits ophthalmologist	Yes	1 year ago	

Lifestyle/Behavioral Risks:

Eating Habits:	Healthy. Low fat
Exercise:	Swim 3x a week
Sleeping Habits:	8 hours
Stress:	Minimal
Tobacco:	No
Alcohol:	3-4 beers on weekend.
Illicit Drugs:	No

Sexual Habits:

Current:

Monogamous:	Yes
Number of partners:	1
Orientation:	Heterosexual
Form of birth control:	Condoms
Safe sex practices:	Yes

Past:

Monogamous:	Yes
Number of partners:	2
Orientation:	Heterosexual
Form of birth control:	Condoms
Safe sex practices:	Yes

History of STDs:	No
Tested for HIV:	Yes-Negative

FAMILY MEDICAL HISTORY

Mother:	Deceased – Leukemia when you were three
Father:	Alive – (add 20 years to your age) has high blood pressure and cholesterol
Sister(s):	No
Brother(s):	No
Grandparents(s):	All deceased
Spouse's Health:	N/A