

Enter Patient Name Here

Case Number Enter Case Number Here

Module:

Patient Profile

Patient Name is a <age> year-old <cultural heritage> <gender> , who presents to the <location> . with <presenting symptom> .

Table of Contents

Enter Patient Name Here 1

Case Number Enter Case Number Here 1

Module: 1

Patient Profile 1

Table of Contents 1

Subjective 3

Chief Complaint/History of Present Illness 3

Past Medical History 3

Personal Health Influencing Behaviors 3

Family Medical History: 3

Sexual History 3

Social History and Lifestyle 3

Review of Systems 3

Objective 5

Vital Signs 5

General Appearance 5

Diagnostic Studies 6

Facilitators: 6

Diagnostic Tests – Group 1 7

Diagnostic Tests – Group 2 8

Diagnostic Tests – Group 3 9

Diagnostic Tests – Group 4 10

Diagnostic Tests – Group 5 11

Diagnostic Tests – Group 6 12

Diagnostic Tests – Group 7 13

Diagnostic Tests – Group 8 14

Diagnostic Tests – Group 9 15

Diagnostic Tests – Group 10 16

Diagnostic Tests – Group 11 17

Assessment 18

Plan..... 19
Discussion Questions 20
Other Information 22
 Selected Resources..... 22
 Authors..... 22
Case Summary for Facilitators 23
Significant Features of Case 24

[↑ return to the beginning of this case](#)

Subjective

Chief Complaint/History of Present Illness

[This segment should contain information that elaborates on the chief complaint. The narrative should address crucial questions relevant to the chief complaint that are listed in the Standardized Clinical Behaviors associated with this clinical presentation.]

Past Medical History

Past Illnesses: denies any significant past illnesses.
Injuries: denies any past injuries.
Immunizations: denies recent immunizations for tetanus, hepatitis A or B, pneumonia, or influenza; no TB test within the last 10 years.
Medications: presently takes no prescription or non-prescription medication, on a regular basis.
Allergies: denies any significant drug or environmental allergies.
Surgical History: has had no surgery.
Hospitalizations: has never been hospitalized.

Personal Health Influencing Behaviors

diet: eats a balanced diet.
exercise: follows no particular exercise plan.
sleep patterns: sleeps approximately six hours nightly.
caffeine use: denies the use of caffeine.
alcohol use: denies the use of alcohol.
nicotine use: denies the use of nicotine
other substances: denies the use of recreational substances

Family Medical History:

no family history of cancer, diabetes, high blood pressure, stroke, heart disease, arthritis, mental health problems, or alcohol/substance abuse.

Sexual History

[This segment should describe the patient's past or present sexual behavior that may affect health care.]

Social History and Lifestyle

[This segment should contain information that assesses the health impact of the following:]
spouse/parent and family relationships?
potential for violence or abuse?
friends/support group?
faith or spiritual beliefs that impact health care?
hobbies/ "fun"?
occupation?
education level?
recent stresses?
life goals?
life concerns/fears?
Insurance status?

Review of Systems

- **Cardiovascular**

The patient denies any recurrent chest discomfort, palpitations, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, hypertension, edema, cyanosis, cardiac murmurs, phlebitis, varicosities, or claudication.

- **Respiratory**

The patient denies any history of pain in or unusual drainage from the ears, nose, or throat. He does not suffer frequent nosebleeds. He denies recurrent chest pain, wheezing, chronic cough, hemoptysis, pneumonia, tuberculosis, fever, or night sweats.

- **Gastrointestinal**

The patient denies any history of recurrent abdominal pain, chronic indigestion, pyrosis, food dyscrasias, anorexia, recurrent nausea, vomiting, diarrhea, constipation, hematemesis, abnormal stools, jaundice, hemorrhoids, or recent change in bowel habits.

- **Genital/Reproductive**

The patient denies any history of genital lesions, sexually transmitted diseases, genital discharge, discomfort during sexual activity, or concern with libidinal drive.

- **Urinary**

The patient denies any problems with urinary urgency or frequency, dysuria, nocturia, hematuria, polyuria, facial edema, oliguria, recurrent kidney or bladder infections, difficulty starting urinary stream, change in size or force of urinary stream, kidney stones, incontinence, or urinary retention.

- **Musculoskeletal**

The patient denies any past problems with muscular strains, injuries, chronic back pain, recurrent joint pains or swelling, joint infections, arthritis, weakness, atrophy, or muscle cramps.

- **Endocrine**

The patient denies any history of diabetes mellitus, thyroid disorder, polydipsia, polyuria, alopecia, excessively dry skin, temperature intolerance, or recent weight change.

- **Neurological**

The patient denies any history of headaches, seizure disorder, stroke, paralysis, tremor, incoordination, paresthesias, syncope, gait disturbance, dysarthria, dysphagia, visual, hearing or speech problems, or changes in memory capacity.

- **Psychiatric**

The patient denies any past history of nervous or emotional difficulties, chronic anxiety, depression, or hospitalization for psychiatric treatment.

- **Integumentary**

The patient denies rashes, itching, easy bruising, changes in skin color or dryness, lumps in skin, or changes in hair or nails.

[↑ return to the beginning of this case](#)

Objective

Vital Signs

Temperature: XX °F Height: XX inches
Pulse: XX bpm Weight: XX lbs
Respirations: XX rpm
Blood Pressure: XX mmHg

General Appearance

HEENT:

Head: normocephalic

Eyes: conjunctiva clear; pupils 3 mm in size, equal and reactive to light and accommodation; consensual light reflex intact; external ocular muscles intact; visual fields are appropriate; no nystagmus (vertical, horizontal or rotary) in the sitting position.

fundoscopic exam: normal light reflex, A:V ratio = 3:4., normal cup to disk ratio, with sharp disk margins and spontaneous venous pulsations; no AV nicking, and no hemorrhages, exudates, or papilledema.

Ears: external auditory canals patent and clear of debris; tympanic membranes are pearly gray, and display normal cone of light and normal bony landmarks; no TM inflammation or perforation.

Nose: no swelling of nasal turbinates; no nasal discharge; septum midline without deviation, or perforation.

Throat: no pharyngeal inflammation or exudates; tonsils absent; uvula midline; tongue midline; dentition healthy; no oral lesions or leukoplakia.

Face: symmetrical; no maxillary or frontal sinus tenderness

Neck: supple with no rigidity, tenderness, muscle spasm, or palpable masses; no lymphadenopathy; thyroid is not palpable; trachea is midline and movable; no JVD; no carotid bruits.

Heart: apical impulse palpated in left intercostal spaces four and five, lateral to midclavicular line; regular rhythm; normal S1 and S2; no S3 or S4; no murmurs, gallops or rubs.

Lungs: clear to auscultation and percussion; full breath sounds bilaterally.

Chest: no tenderness to palpation.

Breast: no masses, discharge or tenderness noted.

Abdomen: no distention; no tenderness to palpation; no masses or organomegaly; no fluid wave; no hepatjugular reflux; no inguinal lymphadenopathy; bowel sounds present; no bruits auscultated;

Rectal: no masses, unusual tenderness, or evidence of bleeding;

Back: cervical, thoracic, and lumbar curvatures are normal; no scoliosis noted; range of motion is unrestricted in cervical, thoracic, and lumbar areas;

Extremities: no cyanosis or clubbing; no edema or varicosities; no restriction of range of motion; check of pulse – radial, brachial femoral, posterior tibial, dorsalis pedis are grossly intact

Skin: no rashes, unusual scarring or tumors;

Genital: no unusual tenderness, swelling or discharge noted;

Neurological: affect and orientation are appropriate; cranial nerves, sensory and deep tendon reflex evaluations show no abnormalities; no pathological reflexes are present.

Osteopathic Structural exam: (2 positions here). Patient was examined in Comment should include aspects of tissue texture changes, asymmetry of motion, patient tenderness.

Diagnostic Studies

This information is not included in student editions of this case. Students may access this information using the password-protected group edition found on the course website (Blackboard). The group's facilitator will provide the password at the appropriate time.

Facilitators:[†]

When it is appropriate, please share the following password with your group so that the group edition of the case can be accessed.

Filename: Enter the name that will be used on Blackboard to identify the GROUP VERSION of this case

Password: Enter the password that will be used when saving the GROUP VERSION of this case

[↑ return to the beginning of this case](#)

[†] This information is published in the Group edition and Facilitators' edition only. It is NOT included in the Student edition.

Diagnostic Tests – Group 1 †

If desired, enter the name for this category of tests here

Test Name

Results

Normal

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 2 [†]

If desired, enter the name for this category of tests here

Test Name

Results

Normal

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 3 †

If desired, enter the name for this category of tests here

Test Name

Results

Normal

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 4 †

If desired, enter the name for this category of tests here

Test Name

Results

Normal

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 5 †

If desired, enter the name for this category of tests here

Test Name

Results

Normal

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

Enter test name here

Enter value here Enter units here

Enter range here Enter units here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 6 †

Enter the name of this imaging study here

RESULTS

If possible, insert image here

Enter bibliographic information regarding the source of the image here

NORMAL

If possible, insert an image depicting NORMAL results here

Enter bibliographic information regarding the source of the image here

REPORT

Enter the specialist's report here

IMPRESSION

Enter the specialist's impression here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 7 †

Enter the name of this imaging study here

RESULTS

If possible, insert image here

Enter bibliographic information regarding the source of the image here

NORMAL

If possible, insert an image depicting NORMAL results here

Enter bibliographic information regarding the source of the image here

REPORT

Enter the specialist's report here

IMPRESSION

Enter the specialist's impression here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 8 †

Enter the name of this imaging study here

RESULTS

If possible, insert image here

Enter bibliographic information regarding the source of the image here

NORMAL

If possible, insert an image depicting NORMAL results here

Enter bibliographic information regarding the source of the image here

REPORT

Enter the specialist's report here

IMPRESSION

Enter the specialist's impression here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 9 †

Enter the name of this BIOPSY study here

RESULTS

If possible, insert image here

Enter bibliographic information regarding the source of the image here

NORMAL

If possible, insert an image depicting NORMAL results here

Enter bibliographic information regarding the source of the image here

CLINICAL SUMMARY

If appropriate, enter text here

PREOPERATIVE DIAGNOSIS

If appropriate, enter text here

POSTOPERATIVE DIAGNOSIS

If appropriate, enter text here

PROCEDURE

If appropriate, enter text here

TISSUE SUBMITTED

If appropriate, enter text here

GROSS EXAMINATION

If appropriate, enter text here

MICROSCOPIC DESCRIPTION

If appropriate, enter text here

DIAGNOSIS

If appropriate, enter text here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 10 †

Enter the name of this BIOPSY study here

RESULTS

If possible, insert image here

Enter bibliographic information regarding the source of the image here

NORMAL

If possible, insert an image depicting NORMAL results here

Enter bibliographic information regarding the source of the image here

CLINICAL SUMMARY

If appropriate, enter text here

PREOPERATIVE DIAGNOSIS

If appropriate, enter text here

POSTOPERATIVE DIAGNOSIS

If appropriate, enter text here

PROCEDURE

If appropriate, enter text here

TISSUE SUBMITTED

If appropriate, enter text here

GROSS EXAMINATION

If appropriate, enter text here

MICROSCOPIC DESCRIPTION

If appropriate, enter text here

DIAGNOSIS

If appropriate, enter text here

[↑ return to the beginning of this case](#)

Diagnostic Tests – Group 11 †

Enter the name of this BIOPSY study here

RESULTS

If possible, insert image here

Enter bibliographic information regarding the source of the image here

NORMAL

If possible, insert an image depicting NORMAL results here

Enter bibliographic information regarding the source of the image here

CLINICAL SUMMARY

If appropriate, enter text here

PREOPERATIVE DIAGNOSIS

If appropriate, enter text here

POSTOPERATIVE DIAGNOSIS

If appropriate, enter text here

PROCEDURE

If appropriate, enter text here

TISSUE SUBMITTED

If appropriate, enter text here

GROSS EXAMINATION

If appropriate, enter text here

MICROSCOPIC DESCRIPTION

If appropriate, enter text here

DIAGNOSIS

If appropriate, enter text here

[↑ return to the beginning of this case](#)

Assessment

If available, paste all Assessment information here

[↑ return to the beginning of this case](#)

Plan

If available, paste all Plan information here

[↑ return to the beginning of this case](#)

Discussion Questions

Question 1

Enter question here

Answer 1[†]

❖ Enter list here

Question 2

Enter question here

Answer 2[†]

❖ Enter list here

Question 3

Enter question here

Answer 3[†]

❖ Enter list here

Question 4

Enter question here

Answer 4[†]

❖ Enter list here

Question 5

Enter question here

Answer 5[†]

❖ Enter list here

Question 6

Enter question here

Answer 6[†]

❖ Enter list here

Question 7

Enter question here

Answer 7[†]

❖ Enter list here

Question 8

Enter question here

Answer 8[†]

❖ Enter list here

Question 9

Enter question here

Answer 9[†]

[†] This information is published in the Facilitators' edition only. It is NOT included in the Student edition or the Group edition.

❖ Enter list here

Question 10

Enter question here

Answer 10[†]

Enter answer here

Question 11

Enter question here

Answer 11[†]

Enter answer here

Question 12

Enter question here

Answer 12[†]

Enter answer here

Other Information

Selected Resources

Use proper bibliographic format to cite resources selected by the authors here

Authors

Enter author's name here , Enter author's degree(s) here (without periods)

Enter author's name here , Enter author's degree(s) here (without periods)

Enter author's name here , Enter author's degree(s) here (without periods)

Case Summary for Facilitators[†]

This is a case of . Briefly describe the patient's presentation and final diagnosis here .

This case study encourages the student to:

- Use such verbs as these to describe what students can accomplish through this case.
- review ...finish this sentence...
- investigate ...finish this sentence...
- examine ...finish this sentence...
- research ...finish this sentence...
- correlate ...finish this sentence...
- explore ...finish this sentence...
- analyze ...finish this sentence...

Significant Features of Case[‡]

[Please include a **bulleted list** of the important features of this case contained in each category]

Subjective

-

Objective

-

Assessment

-

Plan

-