Standardized Patient Case Template

The following template can be used to organize information for a standard adult patient scenario.

Advanced Clinical Education Center
Office of Medical Education
M-211 Scaife Hall
3550 Terrace Street
Pittsburgh, PA 15261-1211
Phone: (412) 648-8702
Fax: (412) 383-7477
Email: acec@medschool.pitt.edu
Section 1 Author Information and General Case Information

Date: ______________________

Primary Case Author: ________________________________________________________________

Secondary / contributing author(s): ____________________________________________________

Educational Case Objectives
The most important step in writing a case is to have a clear educational objective in mind. This should include if you are going to use the case for evaluation or teaching, and the level of the learner. Please list the specific case content and interpersonal skills that will be assessed through the use of this case. (Examples: This case will evaluate a fourth year medical student’s ability to – “perform a social history on an adolescent,” “demonstrate a focused physical examination of the heart,” “recognize risk factors for the development of cervical cancer”)

1. ___________________________________________________________________________________
2. ___________________________________________________________________________________
3. ___________________________________________________________________________________
4. ___________________________________________________________________________________

Section 2 Patient Demographics and Description

Patient name: _________________________________________________________________________

Presenting complaint / presenting problem: ________________________________________________

Actual diagnosis / feasible diagnoses: ____________________________________________________

Description: (e.g. gender, age, race/ethnicity, height, weight, hygiene, education, socioeconomic status)

Underlying Emotional State: (e.g. patient behavior, affect, mannerisms - frightful, anxious, angry, hostile)

Patient’s Agenda: (e.g. why has the patient come to see the doctor, what does the patient want)

Type & Location of Encounter: (e.g. new patient, office visit, follow-up, emergency, clinic, telephone call)
Section 3: Case Information

3A. Chief Complaint and History of Present Illness

**Chief Complaint:** (This must be provided in the patient’s own words).

**History of Present Illness:** (e.g. onset, context, acuity, location, radiation, quality, severity, intensity, progression, timing, aggravating factors, relieving factors, associated symptoms)

3B. Relevant Past Medical History

(e.g. hospitalizations, medical illnesses / chronic problems, past surgery, accidents, injuries, medications, allergies)

3C. Relevant Family History

(e.g. father, mother, brother, sister, son, daughter, grandparents, grandchildren, aunts, uncles, cousins)

3D. Relevant Social History

(e.g. living environment, marital status, sexual history, occupation, religious affiliation, hobbies, tobacco, alcohol, drugs, diet, caffeine, exercise)

3E. Review of Systems

(e.g. general, respiratory, cardiovascular, gastrointestinal, urinary, reproductive, neurological, psychiatric, etc.)