Curriculum Components
Case Studies

Suggestions for Case Study Write-Up

I. Patient profile:

Age, race, sex, marital status, city of residence, occupation, last clinic visit, date and reason for visit, overview of past clinic visits, chronic illnesses. (Do not use the patient's name or other references, which will identify him/her.)

II. Chart Review:

History of Present Illness (HPI) Narrative describing the patient's story of illness to include: chronology, bodily location, quality, quantity, setting, aggravating or alleviating factors, associated manifestations, past evaluations and/or treatment. May use numbered sections for separate problems.

Past Medical History (PMH). Childhood health; adult health (illness and hospitalizations, surgery, obstetrical history); accidents and injuries; allergies and immunizations; current medications.

Family History (FH) Family health record: age, diagnoses, manifestations of illness and/or date of death of family members; family disease screening: diabetes, cancer, heart disease, hypertension, anemia, bleeding disorder, epilepsy, TB, asthma, stroke, gout, glaucoma, kidney disease.

Social History (SH) Home environment (residence, family relationships); social adjustment (education, work record, military history, community activities, religious activities, friendships, financial status and medical insurance); marital history; personal habits (sleep, exercise, diet, smoking, caffeine, alcohol and/or drug use); recent stresses and current supports.

Community Agencies and Resources (CAR). Examples of community agencies and resources include Homeless Shelter, Department of Social Services, Home Health Care, Alcoholics Anonymous, The Senior Center, Church, Women's Shelter, and Mental Health Agency.

Review of Systems (ROS) As recorded from most recent medical visit. Examples include: general (fatigue, weight change, fever/chills); integument (dry skin); head (dizziness, head trauma); eyes (blurring); ears (pain); nose (discharge); mouth (toothache); neck (swelling); breast (self-exam); respiratory (cough); cardiovascular (shortness of breath); gastrointestinal (constipation); genitourinary (incontinence); genital tract (date of last menses; discharge); musculoskeletal (joint swelling); hematopoietic (easy bruising); endocrine (cold intolerance); nervous system (tremor); psychiatric (depression).

Physical Examination (PE) As recorded from most recent medical visit. Vital signs and other relevant physical findings.

Medication: Medications per medical chart to reflect patient’s dosage and frequency.

Laboratory Data Include relevant normal values and any abnormal values in recent past, with dates.

III. Your Plan (for the Case Discussion):

From point of view of student presenter's discipline. Diagnostic and therapeutic modalities used in the management of the problem, including lab tests, procedures, medications, further diagnostic plans, patient education, counseling methods, and use of consultants.

Rationale for the Plan of Care (RP). Give a brief reason for each component of the plan of care.

IV. Thoughts/Discussion

A. What are the benefits and challenges of involving community members in the health care of this person?

B. What have you learned from this case and how will you apply your learning in your practice as a physician