Guidance for practice

The guidance we give here will be very helpful for you if you can manage to get a partner. (Not necessarily a medical student, any friend will do, i.e. your wife/ husband).

- You need to ask your partner (SP) to read his/her notes first. It is even easier if he can mark all the positive things.
- Time your practice session. This is very important. Most important to remember is that your time starts before you enter the room. You have 15min starting outside the room.
- After the session is completed (i.e. within 15 minutes) you go and see the checklist for that case. If you do more than 65% usually you will pass in the exam. But, we advise you try to make at least 75% during the practice session. In the exam obviously you will miss many things more easily because of tension. So, don't worry if you miss in the practice session but not in the exam. The only way to overcome this problem is practice, practice and practice ... We advise everyone to practice these cases at least 3 times in a timed manner.
- Please do not skip any part, as you need to time everything for each case.

Abbreviations

Note: This list is intended to cover the most of the abbreviations widely used in the hospitals of USA.

A

Abd	Abdomen
ACEIs	Angiotensin Converting Enzyme Inhibitors
ACTH	Adrenocorticotropic Hormone
ADH	Antidiuretic Hormone
AF	Atrial Fibrillation
AFB	Acid Fast Bacilli
AIDS	Acquired Immune Deficiency syndrome
AML	Acute myeloid leukemia
ALL	Acute Lymphoblastic leukemia

ALS	Amyotrophic lateral sclerosis
Acute MI	Acute Myocardial Infarction
ANA	Anti nuclear antibody
ANCA	Antineutrophil cytoplasm antibody
Anti SMA	Anti smooth muscle antibody
AP	Anterioposterior
aPTT	Activated Partial Thromboplastin Time
AR	Aortic Regurgitation
AS	Aortic stenosis
ARDS	Acute Respiratory Distress syndrome
ARF	Acute renal failure
ASLOtiter	Anti streptolysin O titers
ATN	Acute tubular necrosis

B

BCG	Bacillus Calmette Guerin
bid/tid	two times a day/three times a day
BMP	Basic metabolic profile
BS	Breath sounds/Bowel sounds
BUN	Blood urea nitrogen

C

Ca.	Carcinoma
Ca^{+2}	Calcium
CABG	Coronary Artery Bypass Grafting
CAD	Coronary artery disease
CBC	Complete Blood Count
CBD	Common bile duct
cc	cubic centimeter
CEA	Carcinembryonic antigen
CHF	Congestive heart failure
CCF	Congestive cardiac failure
CK	Creatine kinase
CK MB	Creatine kinase myocardial band
cm	centimeter
CML	Chronic myelogenous leukemia
CMV	Cytomegalovirus
CNS	Central nervous system
c/o	complaining of
COPD	Chronic obstructive lung disease
CPAP	Continuous positive airway pressure
CPK	Creatine phosphokinase
CPR	Cardiopulmonary resuscitation
Cr	Creatine
C/S	Culture and sensitivity
CSF	Cerebrospinal fluid
C-sec	Cesarean section
CT scan	Computed tomography
CVA	Cerebrovascular accident
CVA tenderness	Costovertebral angle tenderness
CXR	Chest X ray

D

D&C	Dilation and Curettage
DIC	Disseminated Intravascular Coagulation
DKA	Diabetic Ketoacidosis
DM	Diabetes Mellitus
DPT	Diptheria Pertussis Tetanus
DTs	Delirium Tremens
DUB	Dysfunctional Uterine Bleeding
DVT	Deep Venous Thrombosis
D5W	Dextrose 5% in water
Dx	Diagnosis

E

EBV	Epstein Barr Virus
ECG/ EKG	Electrocardiogram
ED/ER	Emergency Department/Emergency Room
EEG	Electroencephalogram
ENT	Ear Nose Throat
EGD	Esophago gastro duodenoscopy
EIA	Enzyme immunoassay
ELISA	Enzyme linked immunoassay
EMG	Electromyography
EOMI	Extraocular movements Intact
EPS	Extrapyramidal symptoms
ERCP	Endoscopic retrograde cholangiopancreatography
ESR	Erythrocyte Sedimentation rate
ETOH	Ethanol
Ext.	Extremities

F

F	female
FDPs	Fibrin degradation products
Fe	Iron
FFP	Fresh frozen plasma
FH	Family History
FHR	Fetal Heart Rate
FNAC	Fine needle aspiration cytology
FSH	Follicle stimulating hormone
FTA ABS	Flourescent treponemal antibody absorbed
5-FU	5 fluorocil
FUO	Fever of undetermined origin
Fx.	Fracture

G

gm	gram
GB	Gall Bladder
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
GGT	Gamma glutamyl transferase
GI	Gastrointestinal tract
AGN	Acute Glomerulonephritis
G6PD	Glucose 6 phosphate dehydrogenase
GTT	Glucose Tolerance test
GU	Genitourinary
GVHD	Graft versus Host disease

Gyn.	Gynecology

H

H2	Histamine –2
Hep.A	Hepatitis A Virus
Hb	Hemoglobin
HBcAg	Hepatitis B core Antigen
HbsAg	Hepatitis B surface Antigen
HBIG	Hepatitis B immunoglobulin
HBV	Hepatitis B virus
Hco3	Bicarbonate
Hct	Hematocrit
HCV	Hepatitis C virus
HDL	High density lipoprotein
HEENT	Head, eye, ear, nose, throat
hCG	Human Chorionic gonadotropin
HIV	Human immunodeficiency virus
H/O	history of
HPI	History of presenting illness
hr	Hour
HR	Heart rate
HSV	Herpes simplex virus
HTN	Hypertension
Hx.	History

I

IBD	Inflammatory bowel disease
IBS	Irritable bowel syndrome
IHD	Ischaemic heart disease
IDDM	Insulin dependent diabetes mellitus
Ig	Immunoglobulin
IM	Intramuscular
Inj	Injection
INR	International normalized ratio
IQ	Intelligent quotient
IUD	Intrauterine device
IV	Intravenous

J

JVD	Juglar venous distension
JVP	Juglar venous pulse

K

Kg	Kilogram
KUB	Kidney ureter bladder

L

Lt	Left
LAD	Left axis deviation
LAHB	Left anterior hemi block
Lb	Pound
LBBB	Left bundle branch block
LDH	Lactate dehydrogenase
LDL	Low density lipoprotein
LES	Lower esophageal sphincter
LFTs	Liver function tests

LGV	Lymphogranuloma venereum
LH	Luteinizing Hormone
LLQ	Left lower quadrant
LMP	Last menstrual period
LP	Lumbar puncture
LPHB	Left posterior hemiblock
LSB	Left sternal border
LUQ	Left upper quadrant
LVH	Left ventricular hypertrophy

M

M	Male
MAC	Mycobacterium avium complex
MCP	Metacarpophalangeal
MCV	Mean corpuscular volume
MVP	Mitral Valve prolapse
MS	Mitral stenosis
MR	Mitral regurgitation
MDS	Myelo Dysplastic syndromes
MRSA	Methicillin Resistant Staphylococcus aureus
MSSA	Methicillin Sensitive Staphylococcus aureus
MVA/RTA	Motor vehicle accident/ Road Traffic Accident

N

NA	Not applicable
NaHCO3	Sodium Bicarbonate
Neuro	Neurologic
NIDDM	Non Insulin dependent diabetes mellitus
NG	Nasogastric
NKA	No known allergies
NKDA	No known drug allergies
NL	Normal limits
NPH	Normal pressure hydrcephalus
NPH	Neutral Protamine Hagedorn(insulin)
NPO	Nothing by mouth
NS	Normal saline
NT	Non tender (Abdomen)
ND	Non Distended
NSR	Normal sinus rhythm
NSAIDs	Nonsteroidal anti-inflammatory drugs

O

Obg & Gyn	Obstetrics & Gynecology
Ophth.	Ophthalmology
OR	Operating room
Ortho.	Orthopedics
oz	ounce

P

PR	Pulse Rate
P2	Pulmonic second sound
PA	Posterior anterior
Pap smear	Papanicolaou smear
para	Number of pregnancies
PCP	Pneumocystitis carnii pneumonia

PCR	Polymerase chain reaction
PCWP	Pulmonary capillary wedge pressure
PE	Physical examination/Pulmonary embolism
ped	pediatric
PERRLA	Pupils equal, round and reactive to light and accommodation
PFTs	Pulmonary Function tests
PMH	Past medical history
HPI	History of Present Illness
PID	Pelvic inflammatory disease
PIP joints	Proximal interphalangeal joint
PKU	Phenylketonuria
PMI	Point of maximal impulse
PMR	Polymyalgia rheumatica
PND	Paroxysmal nocturnal dyspnea
PO	By mouth
PPD test	Purified protein derivative
PPD	Packs Per Day (Sigarettes)
PROM	Premature rapture of membrane
prn	As needed
PSA	prostate specific antigen
PSGN	Poststreptococcal glomerulonephritis
PSVT	Paroxysmal Supraventricular tachycardia
Psych	Psychiatry
Pt.	patient
PT	Prothrombin time
PTT	Partial prothrombin time
PTC	Percutaneous transhepatic cholangiography
PTCA	Percutaneous transluminal coronary angioplasty
Path	Pathology
PTH	Parathormone
PUD	Peptic ulcer disease
PVC	Premature ventricular contraction

Q

q	Every
qd	Everyday
qid	Four times daily

R

Rt.	Right
R.R	Respiratory Rate
RBBB	Right Bundle Branch Block
RBC	Red Blood Cell
REM sleep	Rapid eye movement sleep
Rh	Rhesus factor
RLQ	Right lower quadrant
ROM	Range of motion
ROS	Review of systems
RPGN	Rapidly progressive glomerulonephritis
RPR	Rapid Plasma reagin
rt-PA	Recombinant tissue plasminogen activator
RTA	Renal Tubular acidosis
RUQ	Right upper quadrant

RVH	Right ventricular hypertrophy

S

S	Soft (Abdomen)
S1	First Heart sound
S2	Second Heart sound
S3	Third Heart sound
S4	Fourth Heart sound
SA	Sinoatrial
SAH	Subarachnoid hemorrhage
SABE	Subacute bacterial endocarditis
SQ	Subcutaneous
SGA	Small for gestational age
SGOT	Serum glutamic oxaloacetic transaminase
SH	Social History
SIADH	Syndrome pf inappropriate secretion of antidiuretic hormone
SGPT	Serum glutamic pyruvate transaminase
SL	Sublingual
SLE	Systemic lupus erythematosus
SLR	Straight leg raising test
SOB	Shortness of breath
Stat	immediately
STD	Sexually transmitted disease
Surg.	Surgery
SVT	Supraventricular tachycardia

T

Temp.	Temperature
T3	Triiodothyronine
T4	Thyroxine
Tab.	Tablet
TAH	Total abdominal hysterectomy
TB	Tuberculosis
TIA	Transient ischemic attack
TIBC	Total Iron binding Capacity
TSH	Thyroid stimulating hormone
Tx	Therapy

U

U/A	Urinanalysis
Upper GI	Upper Gastrointestinal Tract
USG	Ultrasonogram
URI	Upper Respiratory Tract Infection
UTI	Urinary Tract Infection
UV	Ultraviolet

V

VDRL	Venereal disease research laboratories
VF	Ventricular fibrillation
VLDL	Very low-density lipoprotein

W

WM	White Male
WF	White Female
WBC	White blood cell

WNL	Within normal limits
WPW syndroem	Wolff Parkinson White syndrome
Wt.	Weight
X	
x	Times
Z	
ZDV	Zidovudine

General History

The most difficult part of the exam is time maintenance. The examination must be completed in 15 minutes. You must make the optimum use of your time.

Introduction and greeting:

"Hello Mr. Xyz. Good morning or Good afternoon. I am Dr. xyz. It's nice to meet you (shake hand).

Next ask: "What brings you to see me today?" or "What brings you in today?"

SP will tell you the chief complaint (cc).

Then ask one open- ended question: "Could you please describe to me exactly what is going on or more about your problem?"

After the S. P. gives some extra history ask about any other important facts that haven't been discussed.

Location:

Your initial concern is: "Where is the problem?" or "Can you please show me exactly where it hurts?"

Onset & duration:

Always ask for the onset and duration of the problem so you can know whether the problem is acute, subacute, or chronic.

"When did it first start?" or "When did you first notice the problem/pain?"

If the cc is chest pain: "When did it first start?"

If the cc is vaginal discharge: "When did you first notice the discharge?"

Then ask about the onset: "Was the onset all the sudden or progressive?"

Next, ask follow up questions regarding the cc:

Intensity:

One should always ask about the intensity or severity of the problem, especially if the complaint is pain.

Ex. "On a scale of 1-10, with 1 being the least painful and 10 being the most painful, which number would describe your pain?" or "How would you grade your pain on a scale of 1-10?" - Ask this way and they will definitely give you a number.

If the cc is not a pain you can assess its severity by asking questions such as: "How bad is it?" "Does it interfere with your daily activities?" or "Does it interfere with your sleep?"

Quality:

The quality of the pain may tell you the cause of the pain, i.e. a burning pain as in acid peptic disease and GERD.

"How do you describe your pain?"

Frequency:

Always ask about how frequent the problem is?

Ex." Is it constant?" or "Does it come and go?" If it is intermittent, "How often does it occur? How long does it last? How do you feel between attacks?"

Radiation:

If the complaint is pain ask questions like, "Does the pain move?" or " Has it changed location?"

Aggravating & Precipitating factors:

Aggravating and precipitating factors might give you a clue as to the cause of the problem. For example, if food aggregates the epigastric pain a gastric ulcer is most likely the cause.

Ex1: "What were you doing when it first began? Have you ever found anything that makes your problem/pain worse?"

Ex2: "Do you have any idea of what might have brought this on?" or "What brings it on?"

Relieving factors (alleviating) factors:

Along with aggravating and precipitating factors these will also help you in making a diagnosis. For example: food will relieve pain in duodenal ulcer.

Ask questions like, " Have you ever found anything that makes your problem better?" or "Have you ever successfully treated yourself?"

Associated problems:

Ask another open- ended question:

Ex." Have you had any other problems?" or " Do you have any other symptoms besides chest pain?"

When you ask the SP like this, the SP may ask you "Like what?" That's why you have to continue with all the pertinent positives and negative symptoms.

Fever:

If you think SP's fever is due to infectious origin, or the suspecting condition is associated with fever, you need to ask questions about it:

"Do you have a fever? Have you had a fever?" (If yes), "How long have you had a fever?"

"How high did your fever get? Was it a low-grade or high-grade fever?"

"Is it a continuous or intermittent fever?"

"Is it accompanied with chills and/or sweating?"

Cough:

"Do you have a cough?"

"Is it a dry cough or productive cough?" or "Do you bring up sputum?"

If it is productive then "what color is/was it?"

"Is/Was there any blood in it?"

"Is/Was it foul smelling?"

"How much is/was it?" "Is it a teaspoon (tsp), tablespoon (tbsp), or a cupful (cp)?" (for quantity assessment always use these measurements, even bleeding per rectum).

In all chronic cough patients don't forget to ask about HIV status and tuberculosis. They will not tell you until you ask about his HIV status*. You should also ask about drug intake especially about the use of ACE inhibitors*

Shortness of breath:

"Have you ever had any problems with your breathing? Have you had wheezing?" (They know what wheezing is.).

"How far do you walk on level ground before you have trouble breathing? Do you have to stop to rest to catch your breath?"

"Have you had any attacks of breathlessness in the night?" (PND)

"Do you need to be sitting up in order to get to sleep?" (orthopnea) or "Do you have trouble sleeping while laying down?"

Nausea and vomiting:

"Have you felt nauseated? Do you feel nauseated?"

"Have you been vomiting or throwing up? "

If yes then "How many times? What does the vomitus look like? What color was it? Was there any blood?"

Ask the nature of the vomiting. Example: "Have you had projectile vomiting?"

Headache:

"Have you had headaches? How often and how severe are they?"

Edema:

"Have you had swelling in your arms or legs?" or "Do your ankles swell?"

If 'yes' ask, " Where did you first notice it? "

Ask them about any diurnal variation, " Do they swell more in the day or night?"

Thyroid:

"Have you ever had problems adjusting to temperatures?"

"Has your voice changed recently?" (hoarseness in hypothyroidism)

"Have you noticed any change in your bowel movements?" (constipation in hypo and diarrhea in hyperthyroidism)

"Have you had any weight change lately? Have you lost or gained any weight lately?"

Previous episodes of chief complaint:

"Have you had similar problems in the past?".

Past Medical History:

Here we give you an example of how to elicit past medical history (This would mainly give you an idea of how to frame questions and save time).

You have to use transition sentences often during this part of history taking. Below is an example of a transition question (you would tell the patient what you are going to ask instead of directly jumping into other topic)

Example: "Ok Mr. Brown, now I would like to ask few questions regarding your past medical health. Is that ok with you?"

Allergic history:

Bear in mind that most of the SPs have some sort of allergic history though it is not related to the chief complaint. Therefore, you have to take the allergic history.

In brief, if the patient's complaints are not mainly related to allergies, as would be in menopause or psychiatric cases - Just ask, "Are you allergic to anything?" or "Do you have any allergies?"

If the case is related to allergies, (i.e. shortness of breath, rash, arthritis etc.) you can elicit the history in the following way: "Are you allergic to pets?" (pause then ask for the next allergen) "Are there any drugs you are allergic to? Are there any specific foods you are allergic to? Are you allergic to dust?"

If the SP gives you any positive history then ask follow-up questions: Start off with an open-ended question like: "Could you please describe more about your allergic problem?" If he doesn't open up properly then ask the following questions "How often do you have allergic episodes? Are you taking any medication for that? What kind of allergic reactions did you have?"

Medical problems in the past:

In general, when taking medical history from patient avoid using medical terminology. Use words they are familiar with, *i.e. 'high blood pressure' instead of 'hypertension'. (diabetes is ok)*

In cases related to specific systems the following questions are to be asked:

CNS - "Have you ever had a stroke? Do you have a history of migraine headaches?" "Have you ever had any seizures?"

CVS - "Have you ever had heart problems like a heart attack or heart failure?"

RS - "Have you ever had tuberculosis? Do you have a history of asthma? Have you ever had any lung problems?"

GIT - "Have you ever had stomach problems or ulcers? Have your ever had any problems with your gallbladder or liver?"

RENAL- "Have you ever had any history of kidney infections? Have you ever had any kidney stones? Have you ever had any problems with your prostate?"

THYROID PROBLEMS (Never forget to ask about the thyroid as many cases (Ex: SP with C/O weight loss/weight gain, depression, amenorrhea etc) are related to the thyroid. They will be ready to tell you if you just ask them. They might also give you precisely the name of the disease, like Hashimoto's Thyroiditis or Goiter.

Cancers - "Have you ever been diagnosed with any type of cancer?"

Hospitalization:

Ask about any past h/o hospitalization, trauma and h/o surgeries.

"Have you ever been hospitalized? What for? When?"

"Have you ever had surgery? What for? When?"

"Have you ever been involved in a serious accident? Have you broken any bones? Have you had any serious head injuries?"

Urinary complaints:

If the case is not related to the urinary system just ask: "Have you had any problems with your urination?" or "Do you have any trouble urinating?"

If related to the Genitourinary system, take a detailed history.

- H/O Burning micturition ("Have you had any burning sensation after you urinate? Does it burn when you go to the bathroom?")

- H/O Urgency ('Do you have to rush to the bathroom to urinate? Do you have trouble holding your urine? Do you often feel like you just can't wait to go to the bathroom?")
- H/O Frequency/Nocturia ("How frequent do you have to pass urine? Do you have to wake up in the night to go to the bathroom?")
- H/O Hesitancy ("Do you have to wait before you start urination?")
- H/O Hematuria ("Did you notice any blood in your urine?")
- H/O Pyuria ("Was there any pus in your urine?")
- H/O Straining ("Do you have to strain during urination?")
- H/O Changes in stream of urine ("How is your flow of urine? Is it continuous or is there any dribbling after urination?")
- H/O Incomplete emptying ("Do you feel fullness of bladder even after passing urine?")
- H/O Incontinence ("Have you ever been unable to control the passing of your urine? Are you generally able to ' hold it' until you get to the bathroom?")

Gastro intestinal problems:

If the case is not related to GIT then just ask: " Have you ever had any problems with your bowel movements?"

- "How often do your bowels move?"
- "Have your bowel movements changed?"
- "Are they hard or soft? What consistency? What color?"
- "Have you noticed any black or tarry stools?

Sleep:

Inquire whether he has any problems sleeping. ("Do you have any problems sleeping?")

If so, ask whether he has difficulty falling asleep, staying asleep, or waking up early?

This is mainly required in all psychiatric cases.

Family History:

Before taking the history let the patient know that you will be asking him about his family health, i.e., pose a transition question.

"Ok Mr. Brown, now I would like to ask few questions regarding your family's health. Is that ok with you?" And continue as follows:

"Does anyone in your family have similar problems?"

"Are your parents living?"

If SP says, 'YES', ask, "How is their health?"

If SP says, 'NO', show some empathy like "Oh, I am sorry to hear that. Could you please tell me the cause of their death?"

If necessary ask for the family history of diabetes, high blood pressure, stroke, and heart problems.

Obstetric and Gyn History:

Before taking the history let the patient know that you will be asking about her Obstetric and Gynecological history, (so you will be posing a transition question here.)

"Ok Mrs. Smith, now I would like to ask few questions regarding your gynecological health. Is that ok with you?" continue as follows:

If it is not a Obstetrical/Gynecological case just ask:

"When was your last menstrual period?"

"Are/Were your cycles regular?"

If it is a OB/Gyn case inquire about:

"How old were you when you had your first period?"

"Are your periods regular?"

"How many days does your period last?"

"Have you ever bled between cycles?"

"How many pads do you use in a heavy day?"

"Do you have abdominal cramps/pain with your period?"

"Did you ever notice any bleeding after intercourse?"

"When was your last menstrual period?"

Vaginal discharge:

"Have you ever had any vaginal discharge?"

If YES, then ask "What is the color of the discharge? Does it have any bad odor? Do you have any vaginal itching?"

"Have you had any sores or infections around the vagina?"

Pregnancy:

"Have you ever been pregnant? How many times? Any miscarriages or abortions?"

If YES, "How many times did you miscarry? In which month/week of your pregnancy?" "Do you know the reason (s) for the miscarriage?"

"Have you had any other problems or complications with your pregnancies?"

"How were the births? Did you have any complications during delivery?"

Abdominal pain:

"Have you ever had any pain in your belly?"

If 'YES' continue with all the questions given under ‘pain’ in Present History.

Pap smear:

"Have you been getting regular pap smears? When did you have the last Pap smear?"

Sexual History:

Before taking the history let the patient know that you would be asking about her/his sexual history, so you will be posing a transition question.

"Ok Mr. Brown, now I would like to ask few questions about your sexual history. Please understand it will be kept confidential between you and me. Try to be as honest as possible. Is that ok with you?" Continue as follows: "Are you sexually active?"

If 'YES', "Who is your sexual partner? Do you have any other sexual partners?" or "Do you relate sexually to men, women or both? Are you satisfied with your sexual life?"

If 'NO', inquire the reason. "Do you have any problems in your sexual life? Any loss of interest in sex? Are you able to reach a orgasm?"

"Do you use any means of contraception?"

If 'YES', "What type of contraception do you use? Do you use it regularly? "

For high risk groups, like patients who are not using barrier methods of contraception, patients with multiple sexual partners, and patients with homosexual history, continue with following questions: (Note: most of the time they have this history and so never miss it.)

"Have you ever been tested/treated for sexually transmitted diseases?"

"Have you ever been tested for HIV?"

Social history:

You need to pose a transition question: "OK Mr. Brown, now I would like to know about your social habits and personal life style. Is that ok with you?"

Appetite:

"How is your appetite?"

Diet:

"Can you please tell me about your diet"

"What does your diet mainly consist of?"

"Are you on a special diet?"

For peri/postmenopausal women ask, "Do you take calcium supplements?"

Weight:

"Has your weight changed recently?"

If 'YES', "How much? In what period of time?"

Smoking:

"Do you use tobacco? Do you smoke?"

If 'NO', "Have you ever smoked in the past?" (Most of the SP's have a past history of smoking)

If ‘YES’, "How many packs/cigarettes do you smoke per day? How long have you been smoking?"

"Have you ever thought about quitting/attempted to quit?"

Alcohol:

"Do you drink any type of alcoholic beverages?"

If ‘NO’, "Have you ever consumed alcohol in the past?"

If ‘YES’, "What type of alcohol do you drink? How much do you drink per day? How long have you been drinking?"

Always keep in mind about the **CAGE** questionnaires for suspected alcohol abuse cases (Ex. upper GI bleeding, right upper quadrant pain, epigastric pain.)

"Have you ever tried to **c**ut down on alcohol drinking?"

"Have you ever been **a**nnoyed by other people for your drinking?" or "Have you ever annoyed other people by your drinking?"

"Have you ever had **g**uilty feelings about your alcohol drinking?"

"Do you drink alcohol **e**arly in the morning?"

Drugs:

"Are you currently taking any type of over the counter medications? Any prescription medications?"

"Have you ever tried any recreational type of drugs?"

If ‘YES’ to any of the questions ask, "What kind of drugs? How long have you been taking them? Have you ever injected drugs?"

Occupation & exposure:

"Do you work? What type of work do you do? Is it a stressful job?" (Analyze whether it is mentally / physically stressful Ex: mental: depression; physical: carpel tunnel syndrome (key board users).

"Are you exposed to any health hazards in your work or personal life?"

"Are your work conditions safe?"

"Does your job involve prolonged sun exposure?" (in case of rash)

"Are you exposed to loud noises at work?" (in case of hearing loss)

Exercise:

"Do you exercise regularly?"

Stress:

"Do you have any stresses from your family?"

Travel:

"Have you traveled outside the United states in recent years? When? Where?"

Special Situations:

Angry Patient:

"Mr. xyz, you seem to be very angry. Could you please tell me why that is so? Is there any way that I can help you?"

Uncooperative patient:

"Mr. XYZ, to properly understand your problem, I have to do this test. It won't take more than a minute. I am here to assist you, ok?"

Pain in hand:

"Does your job involve repetitive hand movements like key board operation?" (Carpal tunnel syndrome).

Insect bite:

"Do you remember being bitten by any insects like ticks and/or mosquitoes?" (in any rash case)

Trauma patient:

Sometimes you will see trauma patients with serious injuries, bruises, or gunshot wounds. Avoid painful maneuvers while diagnosing their injuries. Also, be aware that some severely injured patients without insurance will try to refuse expensive treatments. For example, a trauma patient with significant injury to the chest, who has the signs and symptoms of hemothorax, may say he doesn't want to have a chest X –ray. In a case like that, explain that, "We have a social worker. She will help with the financial details. Right now we must take an X-ray to diagnose your condition." In the USA almost every hospital will have a social worker to deal with these kind of problems.

Over talkative patient:

Sometimes the patient may talk endlessly about irrelevant topics. If so respond like this, "Excuse me Mr. Xyz, sorry to interrupt you. I know these things have really been bothering you. However, I need to focus completely on you right now. (or on your present situation)."

Some patients will respond normally but some patients will say, "Are you interrupting me?" (Don't worry they have been told to act like that.) Say the same thing again and say sorry once again.

General:

If you have to say, " I don't know ", say, "I don't know yet" or, "I don't know but I'll find out and will let you know."

Finally there are 2 popular mnemonics for history taking:

LIQOR AAA (LIQOR is Associated with Alcoholic Anonymous) especially if the chief complaint is a pain.

L - Location
I - Intensity
Q- Quantity
O - Origin & duration & frequency
R - Radiation
A - Aggravating factors
A - Alleviating or Relieving factors
A - Associated problems

The other mnemonic used for the same purpose is **"O P Q R S T"**

Onset
Provocation/**P**alliation
Quality
Radiation
Site
Temporal profile

The following is very good for past history for all cases.
"PAM HUGS FOSS"

Previous episodes of chief complaints/Past medical problems.
Allergic history
Medications

Hospitalization (Trauma, surgery…)
Urinary complaints
Gastro intestinal problems
Sleep
Family History
Obstetric and Gynecological History
Sexual History
Social History

Or you can simply prioritize like this (**HRP ASS FM**)

C.C
HPI
Review of systems
Past medical history
Allergies
Social history
Sexual history
Family history
Medications

Note: This is a general way to take case histories. We have included questions for general history taking, as well as questions for specific health issues. You don't need to ask all these questions for every case. Prioritize what you need to know, and ask those questions. The ability to prioritize becomes easier the more cases you practice.

Documentation of Case

Use these shortcuts to save time:

HPI (History of Present Illness):

Write the present history with other positive and negative symptoms.

PMH (Past Medical History):

Follow this acronym so you won't miss any points (In the exam you will still miss some points, so practice well)

PAM HUGS FOSS

P- Past medical problems

A-NKA (No Known Allergies)

M-Medications

H- Hospitalization

U- Urinary Problems

G- GI Problems

S- Sleep

FH (Family History):

Family History

Obg/Gyn:

Sex H:

SH (Social History)

Physical examination

First, write vital signs

Then, focus on main systemic examination

Lastly, write about review of other systems

Tips:

Always write vital signs first

Give a brief comment about Pts general appearance

Note abnormal findings

Note relevant positive and negative findings

Investigations

Always write most specific tests first

List the tests in order of priority

Write all related tests in a single line Ex:: CBC, ESR...

Do not write referrals or consultations

Do not write Rx

Write about breast, renal, pelvic, or genital examinations, if done.

Documentation of normal respiratory examination:

Breathing:

Normal rate

Rhythm

Trachea central

No accessory muscles are acting

Lungs are clear to percussion

Auscultation:

Normal vesicular breath sounds

No wheezes/rales/rubs

TVF is WNL (Within Normal Limits)

Documentation of normal cardiovascular system examination:

Inspection:

No visible scars, heaves

Palpation:

PMI non-displaced/no pedal edema

No thrills

No heaves.

Auscultation:

S1/ S2 heard

No S3 /S4

No murmurs/gallops/rubs.

Lungs are clear

No additional sounds

Documentation of normal abdominal examination:

Inspection:

No scars

No swelling

No visible peristalsis

No visible pulsations

Auscultation:

Bowel sounds are heard

No bruit

Palpation:

Abdomen is soft, non tender

No masses felt

No organomegaly

No CVA tenderness

No rebound tenderness

Percussion:

Tympanic in all 4 quadrants

Liver span is normal

No free fluid.

Documentation of examination of spine:

Inspection:

No obvious abnormalities

Palpation:

No prominent spinous process

No paraspinal tenderness

Range of motion is WNL (with in normal limits).

Gait:

WNL

Reflexes:

2 +

Documentation of normal central nervous system examination:

Mental status:

Pt is alert

Oriented in time, place, person, and intact memory.

Cranial nerves:

II to XII intact

Motor:

5/5 in all muscle groups

DTR:

2 +, symmetric

Sensations are intact to sharp and dull

Cerebellar:

No positive signs

Babinski negative

No meningeal signs.

Documentation of normal HEENT Examination

Head:

Atraumatic

Normocephalic

Eyes:

Visual acuity and visual fields WNL

EOM-intact

PERLA (Pupils Equal, Reacting to Light and Accommodation)

Fundus is normal

Ears:

No tenderness

No ear canal and tympanic membrane abnormalities

Nose:

No external abnormalities

Turbinates are not congested

No masses seen

Throat:

No ulcers

No erythema or exudates

No patches

Tonsils are N

No dental or gum abnormalities

Neck:

Supple

Thyroid is not palpable

No palpable lymph nodes.

On the Day of Exam

- First of all, keep in mind, and try to stay calm about the fact, that you will be just a number in a herd being put through the thing. You completely give up your individuality when you take the exam. Try not to take that personally. It's just the way it is.
- Everything is well organized and timed. The CSA proctors are

very friendly but also efficient.

- Allow plenty of time to get to the test site so when everything goes wrong and you think you'll be late… You won't be! Don't have being late be one of your worries.
- They don't start the registration before 8.30am. At 8.30am.you have to present your permit (The one you got after you confirmed your exam date via phone or internet) and one ID (passport or driver's license).
- If you do not have the permit with you, no sweat, you will just need two forms of ID. Your name is on their list.
- Registration is at 9:00am.
- They offer lab coats, stethoscopes and watches in case someone forgets them.
- They will show an orientation slide show of some new and some familiar information, i.e. You are allowed to palpate axillary and inguinal lymph nodes including the femoral pulse. Postural signs and BP repeat can be ordered in the work-up. Don't waste your time measuring those things.
- Although it was emphasized that using the gloves is fine, I would still recommend washing your hands. (They have only one size of gloves, and seriously, in my whole career as a doctor I have never seen anybody use gloves to palpate the abdomen or percuss the lung.... so why do it now? I was able to wash my hands within 20 seconds.)
- At one side of the orientation room an exam room was set up and there was ample opportunity to use the instruments, try out the bench, the drape, the forks etc. Questions were welcomed and answered nicely.
- The only thing you can bring yourself is the lab coat and stethoscope, everything else is provided.
- In the examination room there will be a Snellen's visual chart at the wall, two tuning forks with different frequencies, cotton swabs/toothpicks, tongue depressors, reflex hammer, ophthalmoscope, otoscope, and a blood pressure cuff.

The actual exam

- The examinees will face the doors and a plastic box will be hanging on each one. It contains the information about the patient

inside. That includes his name, age, setting (ER, office), chief complaint and vital signs (BP, pulse, temperature, and respiration.) When everybody is settled and ready, the signal is given to start the encounters.

- This is when the fifteen minutes start!!! You have to open the box at the door and read the info about the patient.
- At the bottom they tell you what to do, just like in the info booklet. The time you spend reading and taking notes DOES count toward the 15 minutes.
- Do not rush into the room, because once you enter, you will be totally occupied by the SP.
- Try to spend about 45 seconds in front of the door to make a mental note of differential diagnosis. This is extremely important.
- When you are in the room time flies. So budget your time accordingly.
- You do NOT have to write everything down. There is a second copy of the doorway info in the room.
- All patients will be sitting on the exam table in their gown when you enter the room.
- The rooms are small. There is a chair right in front of the bench where you can sit down.
- Also, to the side of the bench there is a little stool with the drape folded on top of it. In the corner there is a little workstation with computer on it, but it's not for you. It is for the SP's to grade your performance.
- Ten minutes into the encounter, you will hear the signal alerting you that there are five minutes remaining. Then at 15 minutes there is a signal that this encounter is over and you have to leave the room. However, be professional. You can finish your sentence then say good-bye to the patient. Ten seconds later there will be a knock on the door and you will leave the room
- Immediately as you leave the room you have ten minutes to write the patient's note. After eight minutes, (this was very helpful), there is a signal to let you know that there are two minutes remaining..
- After the ten minutes you have to put the pen down and wait for

the proctors to collect the patient note and the piece of notepaper. (While writing the note you can still get up, open the doorway info again and read it. I did that twice and it was fine to do as long as you slide it shut again.)

- The next encounter starts after everybody has walked up to the next-door and is positioned again. (This gets into a nice routine and it is over sooner than you think.)
- Most of the people have no idea how they did. There is just no time at all to get everything asked and done the way you would like to. Just remember this, no matter how well you did, you will still feel frustrated afterwards.
- It's completely normal and I think a definite part of the test function. It measures how well you can cope with time pressure and frustration.

List of Cases

Miscellaneous Key to Success Communication Skills Guidance for better practice On the Day of Exam CSA FAQ **Sample Cases** Alcoholism Back pain Confusion Chest Pain Chronic Cough Chronic Diarrhea Dark urine Depression Diabetic Drug Refill Dizziness Domestic Violence Enuresis Forgetfulness/Alzheimer's Headache Heel pain Hemoptysis Insomnia	cough Case 6: 50-year-old male complaining of fatigue and loss of weight Case 7: 30-year-old male came to HIV drug refill Case 8: 35-year-old female came for evaluation of jaundice Case 9: 26-year-old male with acute onset diarrhea Case 10: 66-year-old male complaining of constipation Case 11: 50-year-old male complaining of impotence Case 12: Mother of 1 Yr. O/Baby With Fever Case 13: 45-year-old female c/o acute, right upper quadrant abdominal pain Case 14: 24-year-old female came for prenatal visit for the first time Case 15: 60-year-old male complaining of acute shortness of breath Case 16: 40-year-old female with increased urination Case 17: 25-year-old female complains of

Menopause Night sweats Obesity Preemployment checkup Shoulder pain Spells Vaginal Bleeding Vomiting Terminal cancer Telephone Encounter **Other** Palpitations Counseling Other imp Cases	sore throat Case 18: 35-year-old female complaining of Chest Pain Case 19: 45-year-old male complaining of Rt lower abdominal pain Case 20: 55-year-old male with bilateral leg pain Case 21: 40-year-old male with vomiting of blood Case 22: 55-year-old male complaining of Chest Pain Case 23: 70-year-old male complaining of Frequent Falls Case 24: 35-year-old male complaining of cough and chest pain Case 25: 60-year-old male complaining of lower abdominal pain Case 26: 35-year-old male complains of fatigue Case 27: 65-year-old female complaining of loss of hearing Case 28: 53-year-old male with right knee pain and swelling Case 29: 50-year-old male with blurred vision Case 30: 32-year-old

	female with multiple bruises Case 31: 20-year-old female with burning urination Case 32: 50-year-old male with difficulty swallowing Case 33: 56-year-old male for BP Check and refill of the medications Case 34: 16-year-old female with amenorrhea Case 35: 35-year-old female with acute right lumbar and lower abdominal pain Case 36: 70-year-old male with insomnia Case 37: 65-year-old male patient with difficulty urinating Case38: 45-year-old female complains of breathlessness and anxiety Case 39: 53-year-old male with a long history of epigastric pain Case 40: 45-year-old male complaining of bloody vomiting Case 41: 60-year-old male complains of dizziness Case 42: 30-year-old male with new onset of

	seizure Case 43: 23-year-old male with rectal bleeding

Why do students fail? Every student who appears for the CSA is capable of passing. Then, why do certain students pass and certain students fail?

- Based on my observations there are several apparent reasons why certain students fail. Becoming aware of these reasons you can avoid potential pitfalls while taking the CSA.
- TIME MANAGEMENT is key!
- The best way for success is repeated timed practice of simulated cases on real people. Practice, practice, and more practice...
- Most of the candidates who appear for CSA mess it up by becoming nervous and anxious. Don't do that. Maintain your cool and composure.
- Don't be over confident. Some of my friends who got above 90 in both the steps flunked the CSA. They thought that they could easily pass the CSA and they did not do the preliminary preparation required for the CSA. That doesn't mean the CSA is tough. If you think you speak English well and you will pass because you are fluent, think again. This exam not only tests your communication skills, but how you collect and digest info to reach a diagnosis, and your writing proficiency.
- If you fail, don't feel depressed. It's not the end of the world. It just means you need to regroup, brush up on your technique, and try again. Don't give up!
- If you are poor in English, try to improve it. You don't have to speak like a Native American but you should be able to communicate clearly with the patient. You might want to consider having several sessions with an ESOL teacher who could evaluate your dialogue and help you with pronunciation and the word order of your sentences.
- Read the CSA orientation manual well. The exam is very similar to it.

- The exam is a very basic assessment of your data gathering ability (history taking), communication, and interpersonal skills.
- You need to know how, and become proficient at, taking a highly focused history and P/E in 15 min.
- When they say **focused**, they mean **focused**. If you overdo the history taking your communications part will suffer. Remember: ***manage your time well.***
- Try to be half way through the P/E when they announce that five minutes are remaining.
- Unfortunately, up to 80% of student's failure of the exam is due to data gathering. So, don't neglect that part.
- The way you introduce yourself to your patient is very important. The following introduction appears good, but is not: "Hi, my name is Dr. . How are you doing today? What brings you here?"

1. The main fault with the above introduction is that the patient is never addressed by name.
2. The correct way to introduce yourself is, "Hello Mr.____ (patient's last name) I'm Dr.____ (your last name). What brings you here today?"
3. Always address the patient by name and never introduce yourself without addressing the patient.

- Keep as close as possible to the CC and related history. When asking the family history or past history, use broad open questions. If there is anything significant, they will tell you. In fact, they will be anxious to answer the questions.
- Expect every day common cases only.
- Remember to knock on the door, shake his hand, and show him your teeth!!! ***SMILE!***
- You may be nervous with the first S.P. Never panic.
- The first S.P may be the hardest because you don't know what to expect. Remember to concentrate, make the best use of your time, don't leave the room early, and don't rush the patient.
- Take a good history and make a mental note of the questions you must ask for a particular symptom.
- Most patients are spontaneous up to a point, but then ask them specific questions to further explore the symptoms.

- Study the differentials of common symptoms, two to three of the most common in America will do. You can't rule out more in 7-8 minutes time.
- Prepare differentials of common symptoms not diseases.
- Always be polite and smile, even if the patient is acting difficult.
- Use common sense, and try to communicate effectively. Getting the message across is more important than talking endlessly.
- If a patient is in pain, don't immediately start interrogating him like an FBI agent. But ask him if he can answer some questions so you can better understand the cause of his pain.
- Do a focused history and always address the patient's concerns as you go. Always be honest with him.
- Don't waste time on a complete history; move from stage to stage quickly and efficiently.
- Always wash your hands before the physical examination.
- Always remember to drape the patient well.
- Try to have a running commentary with the patient. This means explain what you are going to do before actually doing it and if possible explain things as you go. For example: "Now, I'm going to listen to the heart sounds by placing the stethoscope on different areas of your chest."
- Keep your thoughts flowing. You cannot stop, even for a second, in front of the patient to think.
- A good technique to help you review whether you've asked all of the important questions or not is to concentrate on them while you're listening to the patient's heart or breath sounds. That is, pretend you are listening to these things but mentally be going over your checklist of the history intake. Most of the vital signs of the standardized patient will be normal so don't worry that you will miss findings.
- Help the patient move from one position to another.
- Make sure the P/E is focused on the chief complaints.
- Stay focused and calm throughout the exam.
- At the end of everything, help the person tie the gown, sit up, and then seat yourself on the footstool. Good closure is extremely important. Good closure involves discussing your possible deferential

diagnosis (Don't panic if you have only one. Never say that you know the diagnosis. Instead, tell the patient the several possibilities you are considering and that you will need to wait for the test results before giving your diagnosis.)

- Take time to explain your findings and your diagnostic plan of management with the patient at the end of the encounter.
- Tell the patient that you are concerned about him and would like to discuss his condition further with him when his tests get back.
- Make sure the SP understands every thing you have planned for him.
- Be sure to talk about risk factors with the patient and offer the appropriate counsel.
- The standardized patient definitely asks you certain questions. Don't evade them. Be ready to answer challenging questions with common sense. It's very important that you be honest with your answers. If you're not sure, tell the patient that you don't know at this time but will get back to him with the answers to his questions and concerns at your next meeting.

1. Ex. Like when you are dealing with a case of pericarditis the patient may ask, "Is this an episode of heart a attack?"

- Your reply should be: "It really doesn't look like an episode of a heart attack because the pain is chronic, postural, and increased by breathing. Although, I can't rule out the possibility completely. I'm going to do some investigations, and will get back to you."
- Before leaving, ask if there is anything else they would like to talk to you about.
- A difficult patient is one who will not answer your questions in a polite manner. This is by design to see your response. Remain calm, smile, and try to extract the best history possible. Behave like a professional doctor doing your job and move on from there. Remember that they have been told to act like that. Try to determine why he is behaving in a particular fashion. For example, if he is angry, you could say, "Mr. xyz, you seem to be angry. Could you please tell me what's wrong and is there anyway I can help you?"
- Be confident. Confidence is the key to success, Never lose your

cool.

- Avoid the temptation to be overly friendly with the patients. Remember, you've spent $1,200+ to take this exam, {not to mention a few $1000 more to get to Philly or Atlanta and for accommodations etc.}, so there's a lot at stake.
- Memorize the patient note format in the CSA orientation Manuel.
- Know the abbreviations given in the ECFMG booklet/USMLEWORLD and practice using them.

FAQ

Do the SP's show you cards as in OSCE exam?

- The SP's do not use cards to tell you what the abnormal finding should be. The vitals are posted outside the door. If there's an abnormal vital sign, i.e. high blood pressure, as instructed during the introduction, these values as accurate.

Will we be able to detect any physical findings (like bruises, redness etc.) on SP's?

- Some of the abnormal physical exam findings can be acted out, like abdominal pain, weakness, etc. Some may get a patient with a big bruise secondary to trauma. His knee will be painted red to show an inflammatory condition. In some instances the SP (case of sore throat) can have real enlarged tonsils. So look carefully.

I have a problem of stuttering, will that have any effect on my exam?

- Let the CSA people know about your condition. You can do this either by filling in the handicapped section in the CSA application or by sending them a letter describing your problem. They will respond to you and will also inform the SP's. Just to be on safe side, tell the SP's about your problem before you start (of course after you greet and introduce yourself).

I heard there is a problem accommodating couples in a few hotels. Is it true?!!!

- The only problem accommodating couples is at the Divine Tracy

hotel. It is run by a religious order and has specific dress code rules and houses men and women on separate floors. The prices can't be beat. However, if this isn't of interest to you, the other more expensive hotels are readily available if you make your reservation soon enough or try the Internet.

During your patient encounter, you may be asked some questions, which might catch you, off-guard. These questions may be about the patient's fears, concerns, or simple curiosity. Such questions are intentionally included to assess your communication and counseling skills, as well as your concern for your patient.

Below, a list of scenarios and challenging questions has been discussed so that you may get an idea of what kind of questions you will encounter in the exam. Keep in mind that although these cases may be similar, there is still the possibility that you may be asked about a different case with a different challenging question. Simply memorizing these cases should not be your objective. Familiarize yourself with these kinds of cases and questions instead. Use the examples below as guidelines, and not as a script. These are just given to illustrate what kind of questions you should expect. These will also give you an idea on how to respond to such questions. Key pointers to remember are: Expect the unexpected, and then deal with it to the best of your ability. Never lose your composure. Do not panic when you do not know the answer. Here's a very useful trick-of-the-trade: To help you think about a question more (translation: stalling tactics!!!), you can start by saying, "That's a very good question," and analyze the question as you speak. Always look confident. Say everything with conviction. Once you have answered the question to the best of your knowledge, always make sure that the patient was satisfied with your reply. Ask him/her, "Did I address that particular concern or question of yours?" or "Do you have any more questions?" By doing this, you will also have shown how well you can handle pressure! (…even if you don't really feel that way…)

1. **Patients who want a diagnosis / medical opinion**

Some patients may ask for a diagnosis or your "expert opinion" during the encounter. If this happens, just answer the question to the best of your knowledge. Explain why a diagnosis is more likely than the others. If you are not sure about the diagnosis, don't panic. This happens in normal life. Maintain a calm, composed attitude, and admit to the patient that at this point, you are not sure what the diagnosis is since there are several causes,

which could be responsible for his symptoms. Explain the need for further work-up in order to aid you in your differential diagnosis.

Sometimes, a diagnosis may be so life altering or frightening for the patient. Depression may follow after a diagnosis, especially when the disease is chronic or does not have a known cure. Before you give such a definite diagnosis, make sure that the patient has ample emotional and social support to get him through his ordeal. Ask who the patient lives with, who he shares his problems with, and how he handles his problems. Be sensitive to the patient's needs. Do not give him more than he can handle during the patient visit.

1. Demented patient – **Do I have Alzheimer's disease?**
    1. "Alzheimer's disease is certainly a possibility; however, there are also other diseases which could be causing your incoherence or memory loss, such as thyroid problems or vitamin deficiencies. What we can do right now is do some blood work and some other tests first. Once the results come out, I'll be in a better position to tell you your definite diagnosis."

2. AIDS suspect with night sweats/ fever and chills / chronic diarrhea /weight loss – **Do you think I have AIDS?**
    1. "Your lifestyle (IV drug abuse or multiple sexual partners) certainly places you at a higher risk for an HIV infection. Even though HIV is one of the things that can cause these symptoms, there are other conditions, which can cause similar symptoms, and they may be treatable. What we have to do now is do some blood work, including an HIV test, with your permission. When the results come out, we'll sit down to discuss your exact diagnosis and treatment options, okay?"

3. Acute pericarditis/pleuritic type pain patient – **Am I having a heart attack? Am I going to die?**
    1. "Right now, it doesn't look like you're having a heart attack. Based on the information that I got from you, and based on the findings during your physical exam, your condition looks more like inflammation of the heart membranes/ membranes covering the lungs. To be sure, we will be running some tests first. These will be blood work and some imaging studies, and then I'll get back to you with a more definite diagnosis."

4. Patient with weakness or numbness – **Do you think I have a stroke?**
    1. "At this point, I don't know exactly what the cause of your symptoms is. A stroke is a possibility, but there could also be other causes such as nerve pinching, infection, spinal injury, etc. I need to order some blood work and imaging studies before I can tell you for sure."

5. Elderly patient (50 y/o) with constipation and a significant family history of colon cancer – **Do you think this is colon cancer?** or **Do you think I'll get colon cancer too?**
    1. "Your family history certainly places you at risk of getting colon cancer. Constipation could be a symptom of colon cancer; however, there are many other causes of constipation, such as medication side effects, or obstruction of the gut, etc. I want to do a very thorough investigation before I give you a definite diagnosis. Let's do some blood work and imaging studies first, and then when the results come out, we can discuss your problem and treatment options. Does this sound good to you?"

6. Elderly (50-60y/o) patient with impotence – **Do you think I'm just getting old?**
    1. "Age could play an important role in decreased sexual function; however, there are also certain reversible causes which could be causing your problem, such as medication, diabetes, and high blood pressure. If any of these are the cause, then there's a chance that we could correct your problem once we correct the underlying cause. What I'm going to do now is to order some blood tests first. Once the results come out, I'll be in a better position to tell you what exactly is causing your decreased sexual function. We can then discuss your treatment options at that time."

7. Acute Appendicitis patient – **Do you think I need surgery?**
    1. "I understand you could be feeling anxious or scared. Most patients feel nervous when they hear that surgery might be needed. At this point, I cannot rule out the possibility that you may need to be treated with surgery. What I'm going to do now is to order some blood tests and imaging studies first. Once we get the results, we'll be in a better place to discuss your diagnosis, as well as treatment options. We can also go over the benefits and risks of each treatment option by that time. Okay, Mr. XYZ? "

8. Chronic back pain patient – **Do I need surgery?**
    1. "I'll need to order some imaging tests first, so that we can see what the cause of your back pain is. If it can be treated using medication, we will give you pain medication first. If your problem can only be treated by surgery, then we have to proceed with surgery."

9. Pregnant patient with vaginal bleeding – **Do you think I'm going to lose my baby?**
    1. "Well, there are many causes of bleeding in a pregnant patient. Losing the baby - what we call an abortion, is one of them. At this point, it is very difficult to say what the exact cause of your bleeding could be. I need to run

some blood tests and imaging studies to find out what exactly is causing the bleeding."

10. Patient with palpitations and a family history of thyroid problems – **What's causing this, doc? Is it my thyroid?**
    1. "The thyroid is a common cause of palpitations; however, there are other causes, such as heart disease, etc. I'll need to run some tests first, and when the results come out, we'll discuss your diagnosis and treatment options, okay?"

11. Obese patient – **Is obesity genetic? A lot of my relatives are obese.**
    1. "Genetics certainly plays a role in obesity; however, there are other contributing factors that can be attributed to your lifestyle. These other factors could also be affecting your weight. Examples are your diet - how you eat, what you eat, and exercise – if you do enough exercises, and if you do it regularly or not. There are also some other causes such as thyroid problems, etc., that can cause weight gain. We'll figure out the cause of the problem together, and then we'll work on a treatment approach that's right for you."

12. Acute mononucleosis patient – **Can I still play sports? Will I have to give up sports?**
    1. "I have to advise you to stop engaging in any sports activity for the next two to three weeks. Your spleen may be enlarged, and is prone to rupture if you have any trauma when you do sports. I would like you to see me back in two to three weeks. If your physical exam is normal at that time, then it will be okay to participate in sports."

13. Elderly patient (50 y/o) with an abnormal stress test – **In 2 days, my family and I are going hiking. Can I still go?**
    1. "I would advise against it. It is very important that you meet with a cardiologist first, so that he can fully assess your heart function, and provide you with the necessary treatment. You may need heart catheterization. Your stress results are abnormal, and that places you at high risk for getting a heart attack, especially if you go hiking, since it involves strenuous activities."

2. Sensitive issues

Some patients will have concerns, which could be preventing them from obtaining adequate health care. Such cases may involve financial constraints, confidentiality issues, personal fears, etc. When responding to such questions, make sure that you express empathy for the patient. Although the question may be trivial or not that important to you, remember that to the patient, the topic is very important; therefore, you have to address that concern. Healthcare promotion is more effective once

doctor and patient satisfaction are both adequately fulfilled.

1. HIV patient – **Should I tell my wife? I'm scared, doc.**
    1. "I understand that it could feel very uncomfortable or awkward revealing your medical condition. I believe it's always better to reveal the truth. Your wife may have gotten infected with HIV also. She needs to get tested. If you'd like, I could help you inform her, and state the need for her to get tested as well."

2. Acute Appendicitis patient – **I don't have insurance doc. I can't afford an operation. Do I really need surgery? Aren't there other options?**
    1. "I understand your concerns right now, but your condition can only be adequately treated with a surgical procedure. The hospital does have a social worker, and I will arrange for her to discuss any financial assistance that you may be able to get."

3. Patient who needs a lot of laboratory work-up/ extensive diagnostic procedures – **Do you think my insurance will cover these expenses?**
    1. "I'm not sure. I don't have that information with me right now, but I have to stress the importance of this work-up/procedure to your health. At this point, what I can do to help you is to refer you to a social worker so that you can obtain more details on the information you want. If you need a letter to your insurance company describing the procedure and its importance to your health, I'll be glad to write one out for you."

4. Patient with knee injury – **I'm afraid of losing my job if my knee doesn't get better, doc. What should I do?**
    1. "I assure you that I'll do my level best to help. We have to run some tests now to find out the extent of your injury; then, if needed, I can refer you to an orthopedic physician. You can call me if you need a letter or if you need me to call your employer to discuss your healthcare with him, okay?"

5. Single mother who needs to be admitted to the hospital – **I can't be admitted, doc. No one will take care of my children. What should I do?**
    1. "Mrs. XYZ, as your doctor, I have to advise you to stay in the hospital for this procedure (or for antibiotics, work-up, observation, etc.). I understand your concerns, but your health is my concern too. I'll arrange for the social worker to discuss with you any arrangements that they may be able to provide to take care of your children. Okay?"

6. STD patient with a single sexual partner – **Do you think my**

partner is cheating on me?

1. "Since the disease is transmitted sexually, the only way you could have gotten this is through your sexual partner. It's a possibility that your partner obtained it from somebody else. It would be best if you both discuss this further. Right now, I would like your partner to come see me so that we could test him, and then treat him as well, so we can prevent reinfection."

7. Patient with chronic fatigue and nonspecific pain– **Will I ever get better, doc?**
    1. "Your problem could be due to many causes, such as a thyroid problem, anemia, etc. What we have to do now is to investigate your case thoroughly, and check out the possible causes by doing some blood work. Once we find a cause, we could go over your treatment options. Your problem may or may not be treatable. If in case, it is not treatable, we will certainly look at how we can improve the quality of your life, by giving you some medication to take care of some of your symptoms."

3. Medication issues

SP's will sometimes assess your knowledge of medications and their proper use (their indications, contraindications, and side effects). It is important that you answer these questions confidently and with conviction. Even if you're not sure, admit that you're not sure, but do this in a confident manner. Tell the patient that you'll have to get back to him on that question, and that you'll give him a call once you can provide a more definite answer.

1. Elderly patient with chronic osteoarthritis of the knee – **I'm tired of this medication doc, I want to switch to an herbal medication**

    1. "I understand that chronic pain can be very frustrating. Let's go over all the treatment that you've undergone over so far. I understand that some of your friends say that they have benefited from using this herbal drug; however, most studies have not proven herbal medications to be beneficial. Most studies can also be biased, meaning that since the makers of the product usually fund the study, the results that are published are in favor of their product. I would like to take a look at the literature / website you read, and then go over it with you. In the meantime, I would still advise you to continue your medication. I understand this can be very frustrating, but I am concerned about your health, and I want you to get the treatment, which has been proven to be beneficial. Is this okay with you, Mr. XYZ?"

2. Menopausal patient with hot flashes and a strong family history of breast cancer – **Can I go on hormone replacement therapy?**

1. "You're certainly a candidate for hormone replacement therapy, since HRT is indicated for treatment of hot flashes; however, I should inform you that HRT increases your risk of breast cancer."

3. Patients with apparent viral upper respiratory tract infection – **I've had this before. Can't you just give me antibiotics?**
   1. "Based on the information that you told me, and based on the findings from your physical exam, it looks more like you have a viral infection, which doesn't need antibiotic therapy. Antibiotics are not effective in viral infections. Giving antibiotics when it is not necessary could increase resistance to the antibiotics. It could also give you some side effects such as diarrhea and nausea."

4. Explaining medical jargon

During your encounter, we advise that you stay away from all medical jargon. The use of medical jargon creates a feeling of alienation or unfamiliarity, which distances you from your patient. Try to keep yourself from saying all those "fancy, big, medical words." However, if, by accident, a "big word" slips out of your mouth, quickly make up for this episode, and explain the term as simply as you can.

1. Patient in need of colonoscopy - **A colonoscopy? What's that?**
   1. What we do in a colonoscopy is we use a long, thin, flexible tube with a built-in camera, and then insert it from the bottom (your behind), and then look around your intestines for any abnormalities.

5. Difficult patients

These patients will be angry, demanding, or very impatient. Such emotions could also hinder both you and your patient from obtaining an effective and meaningful interaction. Do not disregard these statements/questions, however annoying you think they may be. Always try to resolve the situation first (*i.e.* calm the patient down), in order to obtain an ideal atmosphere for you and your patient to effectively discuss the medical problem.

1. Patient with acute abdominal pain – **Stop asking me these stupid questions, doc. I'm in pain, so just give me pain medications, okay?**
   1. "I understand that you're in a lot of pain right now. However, I have to ask you a few questions first, and then do a physical exam on you for a couple of minutes before I can give you some medication. I have to be very thorough with my exam to be able to help you. Giving pain medications right now could change some important findings in your physical exam. Please bear with me. I'm very sorry that I cannot give you medication right now. I would very much appreciate

your patience."

2. Demanding patient – **I've been waiting for you for a long time. What took you so long?**
    1. "I'm very sorry that you had to wait so long. I encountered unexpected delays with a few of my patients before you. I'm here now, and I'll try to help you as much as I can."

Closing the encounter

All right, Mr. xyz, thank you so much for your kind cooperation. Now, I'd like to sit down and talk over what I think so far. First, let me summarize." (transition).

- You just told me that __ and __. Also, you said that __ and __, Is that right?
- According to the information I got from you and the examination, I am considering a couple of possibilities. It may be __ (your probable diagnosis) or possibly __(differential diagnosis).
- I need to run some tests in order to find out exactly what the problem is.
- As soon as I get the results, let's meet again to go over everything. At that time, I'll explain the details and we will talk about your options for treatment? Does this sound OK?"
- If it is a psychiatric case, like depression, grief, anxiety, or dementia, ask this question:
- Miss xyz, would you be willing to talk to a counselor or go to a support group?
- If Mr./Miss xyz smokes, drinks alcohol, eats fatty food, does not exercise, uses recreational drugs, has multiple sexual partners, does not use condoms, etc, give the following suggestions:
- Mr./Miss xyz, I have noticed that you__(address the problems) Are you willing to quit? If you need any more help from me, just let me know. I'll be glad to help you.
- Miss xyz, do you have any concerns or questions you'd like to ask before I go?
- Ok then, I 'm glad that I was able to work with you. I will do my

level best to make you feel better.

Thanks for your cooperation, have a good day. Bye for now, take care.

Communication Skills

Things you need to bear in mind through out your encounter with the SP's: (A quick glance)

- Always **knock** on the door before entering the room.
- Once you enter the room **introduce** yourself by name and greet the SP warmly.
- Always use **SP's name** to address him/her.
- Maintain good **eye contact**. This demonstrates your self-confidence and creates a sense of trust and credibility. For example, during abdominal palpation, observe the patient's face for any signs of pain or discomfort. During most of the encounter, you should maintain eye contact.
- Before you ask any specific question always ask a few **open-ended** questions. This is the best way to elicit history from the patient. You may ask three or four open-ended questions on the whole for each case. You can start off your case like this: " What caused you to come in today?" "Could you please tell me more about what's going on?" And so on.
- Ask **non leading** questions.
- Ask only **one question** at a time. Do not ask too many questions at a time. Ask a question, pause and wait for the answer then proceed to the next one. Example: "Does anyone in the family have high blood pressure? (pause and wait for the answer) Diabetes?" (pause and wait for the answer)
- Always pay **attention** and listen to SPs patiently without interrupting them in between.
- Try to **acknowledge** their emotions.
- Use **layman's language**. Try not to use medical terms like hypertension for high blood pressure.
- Use appropriate **transition** sentences.

- **Wash** your hands before starting physical examination.
- **Tell** the SP what you are going to do (one at a time, not the whole procedure)
- **Do not** examine through the gown.
- Ask **SP's permission** before untying the gown. Help him/her undo the buttons..
- Use appropriate **draping** techniques. The rule of thumb is: As little of the body should be exposed as necessary for a set of maneuvers to be performed. For instance, to auscultate the heart or lungs, you should NOT raise the gown up from the waist, exposing the entire torso. Rather, she/he should lower the gown from the top, exposing only the upper chest and shoulders.
- Offer **help** to SP's during examination. (On and off the table) .
- **Never repeat** painful maneuvers and always apologize immediately for any pain it caused.
- **Summarize** the history and **explain** physical findings.
- Express **empathy**. Make appropriate reassurances. **Do not give false reassurance**. (You can convey empathy in a number of ways, including attending to the patient's physical comfort. For example: You should extend the leg rest when the patient lies back and push it back in when the SP sits back up. If the patient is in pain, ask if there is anything you can do to help to feel more comfortable.)
- Ask whether he/she has any **concerns/ questions.** ("Do you any questions or concerns?")

*This is the most important thing that you should never forget to ask.

Case Investigation

These are the common investigations that you should keep in mind while writing Pt notes.

HEENT

X-ray, CT, MRI of head

Eye- Snellen's chart, Visual acuity

Ear- Complete audiometry and tympanometry, Culture/Sensitivity for any discharge

Routine CBC with diff, ESR

CNS

Routine CBC with diff, ESR

X-ray, CT, MRI

Lumbar puncture

Carotid Doppler study

EEG

Electromyography and Nerve conduction studies.

Echocardiogram for suspected embolic phenomena.

Musculoskeletal

Routine CBC with diff, ESR

X-ray

Joint aspiration for culture/ sensitive, cytology, crystals

Rheumatic factor, HLA-B27,

Serum uric acid levels

Antinuclear antibodies, anti dsDNA

Muscle biopsy

CVS

EKG and echocardiogram

Cardiac enzymes (CPK-MB, Troponin, LDH)

Chest X-ray

Lipid profile

Thyroid screen

Serum electrolytes

Respiratory

Routine CBC with diff, ESR

Chest X-ray

Sputum studies (culture/sensitivity, gram stain, AFB)

Pulmonary function tests and spirometry

PPD

ABG and pulse oximetry

Abdominal

Routine CBC with diff, ESR

Abdominal X-ray

Ultrasound of abdomen

LFTs

CT abdomen/pelvis

Upper GI series-Barium swallow, endoscopy, ERCP

Lower GI series- enema, Colonoscopy

Test for fecal occult blood/rectal examination

Pancreatic enzymes (amylase, lipase)

Renal function tests

Endocrine

Routine CBC with diff, ESR

Blood sugar

Serum electrolytes

Serum calcium

Thyroid screen T4/T3/TSH

24hr urinary catecholamines and metabolites

Urine for ketones and sugar.

Psychiatry

CBC and ESR

CT and MRI of brain

Thyroid screen

Electrolytes

Urine analysis

Drug screen / HIV

History Taking:

1. When did you start drinking?

2. On average, how many drinks do you have per day?
3. On average, how many days per week do you drink alcohol?
4. Who referred you here?
5. Have you ever tried to cut down on your drinking?
6. Did anyone ever criticize your drinking?
7. Have you ever felt bad or guilty about drinking?
8. Have you ever had a drink first thing in the morning?
9. How do you feel about yourself? Any mood changes?
10. Do you get anxious over small things?
11. What kind of work do you do for a living?
12. Do you have any marital or sexual problems?
13. Have you had any family problems?
14. Do you have any financial problems?
15. Do you have any other complaints?

Past Medical History:

1. Do you have any other medical problems (diabetes mellitus, peptic ulcer disease)?
2. Have you ever been admitted in the hospital?

Social History:

1. Do you smoke?
2. Do you use recreational drugs (IV drugs)?

Family History:

1. Who else lives with you at home? How are they doing?

Medications:

1. Do you take any medications?

Physical Examination:

1. Wash your hands.
2. Perform observe proper draping techniques.
3. Examine the skin.
4. Check the conjunctiva for pallor and jaundice.
5. Check the oral cavity and dentition.
6. Auscultate the lungs and heart.
7. Palpate and percuss the abdomen. Check for hepatomegaly. Rule out

ascites and hepatic tenderness.

8. Examine the extremities for edema.
9. Examine without the gown, not through the gown.

Investigations:

1. CBC
2. Liver function tests
3. Gamma-glutamyl transpeptidase (GGT)

Counseling:

1. Review the quantity and frequency of current drinking.
2. Explain the risks associated with alcoholism.
3. Explain the patient's responsibility to reduce or stop drinking.
4. Set up a drinking diary.
5. Self-motivate the patient. Inform him about available resources/support groups which could help him.
6. Set up a follow-up appointment.

Backpain Case

Case of an Elderly patient (>50 years) with Back Pain

History Taking:

1. When did the pain start?
2. Can you show me exactly where the pain is?
3. What were you doing when the pain began?
4. On a scale of 1 to 10, how severe is the pain?
5. How do you describe the pain? Is it a sharp, burning, crushing, or heavy feeling?
6. Does anything make the pain better?
7. Does anything make the pain worse?
8. Does it radiate to another region of the body, such as your legs?
9. Do you have any numbness or tingling in the legs?
1. Do you have any weakness in your legs?
2. Do you leak urine without your knowledge?
3. Have you ever had bowel movements without your knowledge?
4. Do you have a fever?
5. Have you had any trauma to your back?
6. How is your appetite? Have you lost any weight?

Past Medical History:

1. Have you had similar problems before? Was it diagnosed? Was it treated?
2. Have you had any bone fractures?
3. Do you have any other medical problems? (Especially cancer or recent infection)
4. Do you have pain in any other joints?
5. Did you use any steroid medications in the past?

Family History:

1. Do any of your family members have osteoporosis or back problems?

Social History:

2. What kind of work do you do?
3. Do you smoke? Have you ever smoked? How much and for how many years?

4. Do you drink alcohol? How long have you been drinking?
5. Have you tried any hormone replacement therapy?

Medications:

1. Do you take any prescription medications? Any over-the-counter medications (calcium and vitamin D)?

Allergies:

1. Are you allergic to any medication?

Physical Examination:

1. Wash your hands.
2. Perform proper draping techniques.
3. Check for spinal tenderness.
4. Check for paraspinal tenderness.
5. Check lower extremity pulses.
6. Check sensations of both lower extremities.
7. Do complete motor and reflex testing of both lower extremities.
8. Do straight leg raising test.
9. Check the lumbosacral spine range of motion.
10. Check the gait.
11. Examine without the gown, not through the gown.

Counseling:

12. Explain physical findings and differential diagnosis.
13. Explain further workup.
14. Advise the patient to take (or continue to take) Vitamin D and calcium.
15. Demonstrate and explain the importance of doing range of motion exercises.

Sample Patient note

CC: 60 yo WF c/o back pain

HPI:
This is a 60 yo WF c/o lower back pain that has been present for 2 months. Pain first began while lifting a waste bag. It is described as constant, with a sudden onset, 5-6/10 in severity, radiates laterally down both legs, aggravated by doing work, minimally alleviated by over-the-counter analgesics (Tylenol). She denies numbness, tingling, weakness, urinary incontinence, fecal incontinence, fever, and trauma to the back. She denies prior history of back pain. **PMH:** She has a history of ankle fracture with trivial trauma. **SH**: Denies

smoking, alcohol. **FH:** Osteoporosis +. **Med:** None **All:** NKDA

PE:
VS: BP 122/80 mmHg, PR 98/min, RR 16/min, T 38.3°C (101°F)
Skin over back: normal appearance, no atrophy, no deformity
Limited ROM with flexion, secondary to increased pain; minimal tenderness present over L1 - L2
Straight leg raise: negative at 90 degrees; Patrick's test: negative
Neuro exam: DTR'S + 2 bilaterally - lower extremities; strength and sensation: symmetric bilaterally; normal gait

DD:
1. Disk prolapse
2. Osteoporosis with vertebral body fracture
3. Muscle strain
4. Pathologic fracture
5. Degenerative joint disease

Investigations:
1. X-ray of lumbar spine
2. DEXA scan
3. Calcium, phosphate, alkaline phosphatase, protein electrophoresis, and acid phosphatase, as needed
4. MRI spine, as needed
5. CBC and ESR, as needed

Chest Pain Case

History Taking:

1. When did the chest pain begin?
2. Do you still have the chest pain or has it resolved?
3. For active chest pain:
    1. What were you doing when the pain began?
    2. Did any event or activity cause the pain?
4. For resolved or intermittent chest pain:
    1. How long has the pain been present?
    2. How often do the episodes of pain occur?
    3. How long do the episodes of pain last?
    4. Does any event or activity cause the pain, for example, walking or exertion?

5. How far can you walk before you experience chest pain or shortness of breath (SOB)?
5. Can you show me exactly where the pain is?
6. Does it radiate to another region of the body, such as your jaw, arms, or neck?
7. On a scale of 1 to 10, how severe is the pain?
8. How do you describe the pain? Is it a sharp, burning, crushing, or heavy feeling?
9. Does anything make the pain better?
10. Does anything make the pain worse?
11. Do you have any other symptoms associated with the pain? Do you have shortness of breath, palpitations, nausea, vomiting, sweating, or lightheadedness?
12. Do you have a fever? Do you have a cough?
13. Have you had any recent chest trauma or exertion involving the arms?
14. Do you have any swelling in the legs? Do you experience any pain in your legs while walking?
15. Have you used any recreational drugs, such as cocaine, in the past 96 hours? *If the patient answers 'no,' ask:* Have you ever used these substances?

Past Medical History:

1. Have you ever had similar problems before? Was it diagnosed? Was it treated?
2. Have you ever had any heart problems?
3. Have you taken any medications? Did it help? When was the last dose?
4. Do you have any other medical problems like high blood pressure or DM? How about high cholesterol?

Family History:

1. Do any of your family members have heart problems? At what age were they diagnosed?

Social History:

2. What kind of work do you do?

3. Do you smoke? Have you ever smoked? How much and for how many years?
4. Do you drink alcohol? How long have you been drinking?
5. *If the patient is female and between the ages of 12 to 50 years:* When was the first day of your last menstrual period?

Medications:

1. Are you taking any prescription medications? Any over-the-counter medications?

Allergies:

2. Do you have allergies to drugs or foods?

Physical exam:

3. Wash your hands.
4. Perform proper draping techniques.
5. Check for JVD.
6. Check the eyes for anemia/pallor.
7. Auscultate the heart.
8. Auscultate the lungs.
9. Check for PMI.
10. Check legs for tenderness and edema.
11. Palpate peripheral pulses.
12. Check for carotid bruit.
13. Palpate the abdomen.
14. Examine without the gown, not through the gown.

Differential Diagnosis:

1. Angina
2. Acute MI
3. Aortic stenosis
4. Pericarditis
5. Aortic dissection
6. Pulmonary thromboembolism
7. Pneumonia

8. GERD
9. Costochondritis
10. Panic attacks

Investigations:

1. BP in both arms
2. CBC with diff
3. 12 lead ECG
4. Cardiac enzymes
5. CXR
6. 2D-echo
7. Fasting lipid panel
8. V/Q scan (if you suspect a PE)
9. ABG/Pulse oximetry (if SOB is present)

Chronic Cough

History Taking:

1. When did the cough start? (Cough of < 3 weeks' duration is defined as acute, whereas cough of > 3 weeks is considered chronic)
2. Is it a dry cough, or do you bring up some sputum? Is the sputum purulent?
3. Was there blood in the sputum at any time?
4. Have you noticed any dripping sensation in your throat, or the frequent need to clear the throat? (postnasal drip)
5. Do you have any facial pain or tooth pain? (sinusitis)
6. Do you get short of breath?
7. Did you notice any wheezing? Any nighttime wheezing?
8. Have you had frequent heart burn? Regurgitation, or sour taste (water brash)? (GERD)
9. Do you have any chest pain?
10. What kind of work do you do? Does your cough get worse when you are at your workplace?

11. Is there anything that makes your cough worse?
12. Is there anything that makes your cough better?
13. Do you ever get a fever? Chills? Any night sweats?
14. Have you lost any weight? How is your appetite?
15. Have you been exposed to any patient who has tuberculosis?

Past Medical History:

1. Do you have any other medical problems? (allergic rhinitis, asthma, sinusitis)

Social History:

2. Do you smoke? Have you ever smoked? How much and for how many years?
3. Do you drink alcohol? How long have you been drinking?
4. Have you ever used recreational drugs?
5. Do you have multiple sexual partners?

Family History:

1. Do you have any family member with a history of lung cancer?

Allergies:

1. Are you allergic to anything, like dust? Pets? (detailed history needed)

Medications:

1. What medications do you take? (especially ACE inhibitors)

Physical Examination:

1. Wash your hands.
2. Perform proper draping techniques.
3. Examine the nasopharynges and oropharynges.
4. Check for tenderness over the sinuses.
5. Look for enlarged cervical lymph nodes.
6. Auscultate the lungs.
7. Percuss over the lungs.
8. Check for tactile vocal fremitus.
9. Auscultate the heart.
10. Examine without the gown, not through the gown.

Counseling:

1. Explain the physical findings and differential diagnosis.
2. Explain the further workup.

Differential Diagnosis:

1. Postnasal drip syndrome and sinusitis
2. Asthma
3. Gastroesophageal reflux disease (GERD)
4. Chronic bronchitis
5. Bronchiectasis
6. Cough secondary to Angiotensin-converting enzyme inhibitors (ACEI) use
7. Malignancy
8. Cough secondary to occupational exposure
9. Tuberculosis (rare in USA)

Investigations:

1. CBC with differential
2. Chest x-ray
3. Sputum gram stain/AFB and culture, as needed
4. Pulmonary function tests, as needed
5. High resolution CT scan, as needed
6. ELISA for HIV, as needed
7. PPD placement, as needed

Case of a 34 yo M who presents with Chronic Diarrhea (more than 4 weeks)

*__Note__: Follow the same approach even if the diarrhea is of 2 weeks duration.

History Taking:

1. Please explain to me, what do you mean by diarrhea? Do you mean an increased frequency, an increased volume, or an alteration of stool consistency?
2. When did the diarrhea start? (differentiate whether it is acute or chronic)
3. Can you tell me about the pattern of diarrhea? Do you have episodes of normal bowel movement in between? (continuous or intermittent)
4. How frequent do you have diarrhea?
5. If you were to choose between mild, moderate, or severe, how would you rate the severity of your diarrhea?
6. Can you describe your stool? Is it watery? Bloody? Fatty?
7. Do you have abdominal pain? (inflammatory bowel disease and irritable bowel syndrome)
8. Have you lost weight? (malabsorption or malignancy)
9. Can you tell me about your diet?
10. Are you exposed to anything, which you might find stressful?
11. Does anything make your diarrhea worse?
12. Does anything make your diarrhea better?
13. Do you have a history of recent travel?

Past Medical History:

1. Did you ever have similar episodes in the past?

- Do you have other medical problems? Do you have diabetes mellitus? HIV? Hyperthyroidism? IgA deficiency?
- Were you ever hospitalized? When? Why?
- Did you ever have any abdominal surgery?

2. Were you ever exposed to radiation?

Social History:

1. What is your occupation?

- Do you drink alcohol? How much do you drink? How long have you been drinking?

- Have you ever used recreational/illicit drugs? How? Are you sexually active? Are your partners male, female, or both? (assess risk for HIV)

Family History:

- Does anyone in your family have a history of diarrheal disease?

Allergies:

- Do you have any known drug or food allergies?

Medications:

- Are you currently taking any medications?
- Have you recently taken any medications, especially any antibiotics?

Physical Examination:

- Wash your hands.

1. Perform proper draping techniques.

- Examine the oral cavity.
- Examine the neck for thyroid masses.
- Auscultate the lungs. (Check for wheezing.)
- Auscultate the heart. (Check for murmurs.)
- Auscultate the abdomen.
- Palpate the abdomen superficially.
- Palpate the abdomen deeply.
- Examine the skin. (Check for flushing and rashes.)
- Examine the extremities for edema.
- Examine without the gown, not through the gown.

Counseling:

- Explain the physical findings and differential diagnosis.
- Explain the necessary workup. (blood tests, stool examination)
- Ask to perform a rectal examination.
- Advise the patient to drink plenty of fluids.

Differential Diagnosis for Chronic Diarrhea:

- Secretory diarrhea (bacterial toxins, ileal bile acid malabsorption, endocrine diarrhea)
- Osmotic diarrhea (osmotic laxatives, carbohydrate malabsorption)
- Inflammatory diarrhea (inflammatory bowel disease, infectious diseases

– Giardia)

- Fatty diarrhea (celiac disease, short bowel syndrome)

Investigations:

1. Rectal examination and FOBT (Fecal occult blood testing)

- CBC with differential count
- Basic metabolic panel (NA, K, Cl, CO_2, BUN, Cr, glucose)
- Stool analysis (weight, pH, fat staining, osmotic gap, laxative screen)
- Stool for fecal leukocytes and ova and parasites; stool culture

Case of a 62 yo M with Confusion

1. The chief complaint of “confusion” has a very broad differential diagnosis. Try to narrow down your differential diagnosis based on the SP's other complaints.

History Taking:

1. Start with a formal greeting.
    1. "What brought you in today?" (Answer: "I don't think I have any problem, but my wife says I am very confused these days.")
    2. "How long has she been concerned about this?" (Answer: "I think for the past two or three months.")
    3. "Is she saying that you are confused all the time or is there any specific time or related specific situation?" (Answer: "All the time, Doc.")
    4. "I understand that you are not much concerned about this, but let me ask a few more questions to find out what exactly is going on. Is that okay with you?" (Answer: "Sounds great, Doc.")
    5. "Do you have any problems with your memory?" or "Has she ever complained about your memory?" ("No.")
    6. "Do you feel any weakness in your extremities?" ("No.")
    7. "Do you feel abnormal sensations like tingling or numbness in your extremities?" ("No.")

8. "Do you feel dizzy?" ("No.")
9. "Have you ever had any jerky hand movements or seizures?" ("No.")
10. "Do you have any history of head trauma?" ("No.")
11. "Do you have any fever?" ("No.")
12. "Do you have a headache?" ("No.")
13. "Have you ever passed out?" ("No.")
14. "How are your bowel movements?" ("They are pretty good.")
15. "How is your bladder function?" ("Good.")
16. "Have you noticed any increased frequency of urination?" ("Yes, I've had this problem for a long time; I usually pee a little bit more.")

2. Remember to ask about the Katz **A**ctivities of **D**aily **L**iving (ADLs) - "**DEATH**" i.e. **D**ressing, **E**ating, **A**mbulating, **T**oileting, **H**ygiene, as well as the **I**nstrumental **A**ctivities of **D**aily **L**iving (IADLs) - "**SHAFT**" i.e. **S**hopping, **H**ousekeeping, **A**ccounting, **F**ood preparation, and **T**ransportation.
    1. "Can you please describe to me a typical day for you? What are your routine activities of daily living? "

Past Medical History:

1. "Do you have a history of diabetes?" ("Yes")
    1. "When were you diagnosed with diabetes?" ("About 25 years ago.")
    2. "Are you on any medication?" ("Yes, I am on insulin.")
    3. "Do you know how much insulin you take daily?" ("Usually, my wife or my daughter gives me my insulin shots.")
    4. "How often do you check your blood sugar?" ("Rarely, like once or twice a year.")
    5. "Is your blood sugar under control?" ("Sometimes.")
    6. "Have you ever been admitted to the hospital for any diabetic-related complications?" ("No") "For any other reason?" ("No, never.")
3. "Do you have any other medical problems?"("Yes, I have high blood pressure.")

    1. "For how long?" ("Same as my diabetes.")
    2. "Are you taking any medications for that?" ("Yes. I'm on atenolol, 25 mg twice daily, I guess.")
    3. "How long have you been on this medication?" ("Around 18 years.")
    4. "How often do you check your blood pressure?" ("Once or twice a year.")
    5. "Is your high blood pressure under control?" ("Not always. Only some times.")
4. "Have you ever had any heart problems?"("No")
5. "Have you ever had stroke?"("No")

Medications:

6. "Other than insulin and atenolol, are you taking any other medications?" ("No.")

Allergies:

7. Every patient must be asked about his/her history of allergies. Do not get a detailed allergy history if the case does not seem related to it, as in this case.
    1. "Are you allergic to anything?"("Yes; to penicillin.")

Family History:

8. "Do any of your family members have similar symptoms?"
9. "Does anybody in your family have high blood pressure? Diabetes?"
10. "Did anybody in your family ever have a heart attack? Stroke?"

Social History:

11. "Do you smoke?"("No.")
12. "Do you drink any type of alcoholic beverages?" ("No.")
13. "Have you ever been diagnosed with any sexually transmitted disease, especially syphilis?" ("No, never.")

1. If you ask this much in the history, it is more than enough. Because of the limited time, you may not get enough from your history for any particular diagnosis. Don't worry.

Physical Examination:

1. Wash your hands.
2. Perform proper draping techniques.
14. Perform the mini mental status exam (**MMSE**). The patient will usually have a normal MMSE.
15. Do an ophthalmoscopic examination.
16. Do a quick cranial nerve examination.
17. Check the gait, muscle strength, reflexes, and sensations.
18. Auscultate the heart and lungs.
19. Examine without the gown, not through the gown.

1. Examinees usually run out of time because of the MMSE and CNS exams; therefore, practice performing these exams quickly and efficiently. Practice repeatedly, so that you won't have any difficulty in managing your time during the exam.

Counseling:

20. We don't think you will have enough time to give counseling; however, it is very important to formally close or conclude the encounter.
    1. Ask, "Do you have any questions?"
1. Explain the importance of tight blood sugar and hypertension control.
    2. "I am sorry to hear that your blood sugar and blood pressure are not under good control. Controlling blood sugar requires determination. Let's discuss your treatment plan, which involves having a proper diet, exercising, and using medication regularly. High blood pressure could indicate that your blood vessels are having trouble. Hypertension/high blood pressure could complicate a diabetic's problem. It could cause stroke, affect the functioning of the heart, and even the kidneys. Again, regular exercise, reduction of weight (if the patient appears overweight), and limiting salt in your food could help in keeping your hypertension in check. I strongly advise you to take regular health maintenance examinations to help control your blood sugar and blood pressure. What do you say, Mr. xyz?" (Sounds

great, Doc.)

Differential diagnosis:

21. Insulin induced hypoglycemia
22. TIA
23. Multi-infarct dementia
24. Electrolyte abnormalities
25. Medications
26. Alzheimer's dementia

Investigations:

27. CBC with differential
28. Urinalysis
29. Serum electrolytes or basic metabolic profile (BMP)
30. EKG and 24 hr Holter monitoring if there is any history of spells
31. Carotid doppler
32. CT scan of the head
33. Chest-X ray

Dark urine

Case of a 20 yo M complaining of Dark Urine

History Taking:

1. What do you mean by dark urine?
2. What color is the urine?
3. When did you first notice the dark the urine?
4. Did it occur suddenly?
5. Is/was there any blood in it?
6. Is/was there an odor?
7. Is it consistently the same color throughout the day?
8. Is the quantity of urine per day decreased or increased?
9. Do you have you any pain associated with urination?
10. Have you had any abdominal pain or back pain?
11. Have you had any fever? Chills?
12. Do you have any nausea? Vomiting? Diarrhea?
13. Have you eaten any food that could cause this change in color, such as berries, colored candy, or beets?
14. Was there a recent history of trauma?

Past Medical History:

15. Have you had similar problems in the past?
16. Have you had any recent infections, such as a sore throat?
17. Have you ever had any previous urinary problems or kidney problems?
18. What other medical problems do you have?

Social History:

19. Do you smoke?
20. Do you drink alcohol?
21. Has there been any change involving your recent sexual activities?

Family History:

1. Does anyone in your family have a history of kidney problems?

Allergies:

2. Are you allergic to any medication?

Medications:

3. Are you taking any medication? (Some medications can cause a change in

urine color.)

Physical Examination:

1. Wash your hands.
2. Perform proper draping techniques.
3. Examine the oropharynx.
4. Auscultate the heart.
5. Palpate the abdomen superficially and deeply.
6. Check for costovertebral angle tenderness.
1. Examine without the gown, not through the gown.

Counseling:

1. Explain the differential diagnosis and necessary workup.
2. Explain the need for a genital exam.
3. Advise the patient to drink plenty of fluids.

Differential Diagnosis:

1. Urinary tract infections
2. Glomerulonephritis
3. Kidney or bladder stones
4. Tumors of the kidney and bladder
5. Acute tubular necrosis
6. Medication-induced
7. Food-induced

Investigations:

1. Urinalysis
2. Urine culture and sensitivity
3. CBC with differential
4. Cystoscopy, as needed
5. KUB, as needed
6. CT scan of the abdomen, as needed

Case of a 40 yo F with Depression

1. During the whole patient encounter, the SP will be in a disinterested mood and talk in a feeble voice. The doctor should always make eye contact with the patient.
2. The bored responses from the patient should not frustrate the doctor.

History Taking:

1. "Hello Mrs. Jones. My name is Dr. Smith. I'd like to ask you a few questions and do a physical exam. Is that ok with you?" (The SP will nod feebly)
2. "What brings you in today?" ("I don't know, Doctor. I feel a bit down.")
3. "How long have you been feeling this way?" ("Maybe three months.")
4. "Mrs. Jones, do you have any idea why you're feeling this way?" (She remains silent.)
5. "Mrs. Jones, I know that you're in a lot of emotional stress. Will you talk with me about how you're feeling and what's worrying you?" (The patient looks at the doctor and then away.)
6. "Is there anything in particular that has brought this on?" ("I don't think so.")
7. "Do you have anybody to talk to you when you feel down?" "(I have an aunt. She lives far away.")
8. "Mrs. Jones, how's your appetite?" ("I don't feel like eating.")
9. "Mrs. Jones, have you lost or gained any weight lately?" ("I've lost about seven pounds this past month.")
10. "How have you been sleeping?" ("I get up early in the morning.")
11. "Are you feeling guilty about anything?" ("I don't think I am being a good mom for my children.")
12. "Do you feel abnormally tired?" ("I have no energy at all. I don't even want to get out of the couch.")

13. "Mrs. Jones, tell me about your daily routine." ("I am a house wife. I do the housework and cook for my children. That's about it.")
14. "Can you tell me about your hobbies and interests?" ("I play the violin and sing in the choir on Sundays. However, I don't feel like doing that anymore.")
15. "Do you have trouble concentrating?" ("Mmm, I don't know.")
16. "Do you find yourself forgetting things?" ("Yeah, I'm forgetting to pay the bills on time. ")
17. "What's your favorite thing to do?" ("Spending time with my children.")
18. "Are you still feeling that way?" "(I don't feel like I want to be with anybody right now.")
19. "Mrs. Jones, have you ever felt like life wasn't worth living? Have you ever thought about killing yourself?" ("Yeah, a couple of times.")
20. "Do you ever think about how you would do it" ("No.")
21. "Do you have guns or pills at home?" ("Yeah, I have a .32 at home.")
22. "Do you feel cold when others don't?" ("No.")
23. "Are you losing any hair?" ("No.")
24. "Do you have any problems with your urination?" ("No.")
25. "Are your bowel movements regular?" ("I have been constipated lately.")
26. "Have you ever had any shortness of breath." ("No.")
27. "Have you had any chest pain?" ("No.")
28. "Have you had a cough that just wouldn't go away?" ("No.")
29. "Do you hear or see things that other people don't?" ("No.")

1. *Do an MMSE at this juncture.

1. "Do you think something is wrong with you?" ("Yeah.")
2. "Are you willing to get help from a counselor?" ("I don't know.")
3. "Would you talk with a counselor if I set it up?"("If you think that would help me.")

Past Medical History:

2. "Now, I need to ask you a few questions about your health in the past. Is this okay with you?" ("Yeah")

1. "Have you ever been hospitalized?" ("No, except when I had my children.")

2. "Have you ever felt like this before?" ("No.")
3. "Are you on any medication?" ("No.")

Allergies:

4. "Do you have allergies of any kind?" ("None that I know of.")

Sexual History:

3. "Now, I need to ask you a few personal questions. Please don't feel embarrassed. Everything you say will be kept confidential."
1. "Are you sexually active?" ("Yes.")
2. "How many sexual partners do you have?" ("A couple of them.")
3. "Your sexual preference is…?"("Males.")
4. "Do your sexual partners use condoms?" ("Yes, they do.")
5. "Have you ever been diagnosed or treated for an STD?" ("No.")
6. "Have you ever been tested for HIV?" ("No.")

Family History:

4. "Now, I need to ask you a few questions about your family so that I can get a clearer picture of your health."
1. "Are you married?" ("I was. Got a divorce 10 years ago.")
2. "Are your parents alive?" ("No, they died of old age.")
3. "Was anyone in your family ever diagnosed with a psychiatric disorder?" ("No.")
4. "How many children do you have?" ("I have two children, 14 and 11 years old.")

Social History:

5. "Now, I need to ask you a few questions about your lifestyle."
1. "Do you smoke?" ("No.")
2. "Do you drink any type of alcoholic beverages?" ("Yeah. I have two shots of scotch on the rocks every night. I've been doing that for the past 10 years.".)
3. "Do you use any recreational drugs?" ("No.")
4. "Do you drink coffee?"("Yeah, one cup every morning.")

Physical Examination:

6. "Now, I need to do a physical. Excuse me for a few seconds while I wash my hands."
1. "I'm going to check your thyroid gland." (Not palpable)
2. "I'm going to check your reflexes." (2+)
3. "I'm going to check your pulse now."
4. "I'm going to listen to your heart and lungs now."
7. "Thank you, Mrs. Jones, for your cooperation."
8. Remember to examine without the gown, and not through the gown.

Counseling:

1. "I'd like to sit down and tell you what I think so far."
2. "It appears that you are having an episode of depression. However, I'm going to run some tests first."
3. "I am going to order a blood test to see if you have any problems with your thyroid. Once we get the results I'd like to talk with you again and see if we can help you to start feeling better."
4. "Do you have any questions for me?"

Differential Diagnosis:

1. Depression
2. Hypothyroidism
3. Occult carcinoma

Investigations:

1. Serum TSH
2. CBC with differential
3. Urine and serum toxicology screen

Diabetic Drug Refill

Case of a 50 yo M Diabetic who came for Medication Refill

Vital Signs:

1. BP 135/70 mm Hg
2. Pulse 73/min

3. RR 16/min
4. T 36.7C(98F)

History taking:

1. When were you diagnosed with diabetes?
2. Are you currently taking any medications for diabetes?
3. Are you taking your medications regularly?
4. Do you think that your medicine is controlling your diabetes effectively?
5. Have you ever taken insulin?
6. How often do you check your blood sugar? *or* Do you check your blood sugar regularly/according to your previous physician's advice?
7. How has your blood sugar been lately? How high did it go? Can you tell me the usual range of your blood sugar?
8. Do you have any problems that you would like to talk about?
9. How is your vision? Do you think there is any change in vision lately?
10. Do you feel any abnormal sensations in your legs, like pins or needle prick sensations? Any tingling or numbness?
11. Have you ever had any chest pain?
12. Do you have any breathing problems?
13. Are you sexually active? Do you have any problems during sexual intercourse?
14. How are your bowel habits? (*Or)* Do you have regular bowel movements?
15. Do you have any problems with urination?
16. How is your appetite? Have you lost or gained any weight lately?

Past Medical History:

1. Have you ever been hospitalized for diabetic complications or for any other reason?
2. Do you have any other medical problems like high blood pressure?

Allergies:

3. Are you allergic to anything?

Medications:

4. Are you taking any medications besides diabetic drugs?

Social History:

5. Do you smoke?
6. Do you drink alcohol?
7. Do you exercise regularly?

Physical Examination:

1. Wash your hands.
2. Perform proper draping techniques.
1. Do an ophthalmoscopic examination. (Check for DM retinopathy).
2. Auscultate the neck to check for carotid bruit.
3. Palpate the precordium for PMI. (Check for cardiomegaly.)
4. Auscultate the heart.
5. Test sensation in both legs.
6. Check distal pulses in at least two places
7. Even if the SP is wearing shoes or socks, please don't forget to instruct him to take them off to examine the feet!
8. Examine without the gown, not through the gown.

Investigations:

1. CBC with differential count
2. Blood glucose
3. HbA1C
4. BUN and Serum Creatinine
5. Lipid Profile

Case of a 65 yo F with Dizziness

1. In real life (as well as in the step 2 CS!), evaluating a patient with dizziness can be challenging and frustrating for the clinician. “Dizziness” is a nonspecific term. When a patient complains of being dizzy, he/she may be experiencing vertigo, non-specific "dizziness", disequilibrium, presyncope or

near syncope. It is therefore very important to obtain an extensive history in order to narrow down your differential diagnosis.

History Taking:

1. "What brought you in today?" ("I feel dizzy.")
2. "Can you please explain to me a little bit more about your dizziness?" ("I always feel dizzy. I don't know what you want me to explain.")
3. Make good eye contact and say, "Well Mrs. XYZ, it looks like you are not in a good mood. I am here to help you. Are you comfortable? Is there anyway that I can help you?" ("My mood is fine. Just help me get rid of this dizziness.")
4. "Ok, I do understand that most people with dizziness are not happy. It's miserable feeling dizzy all of the time. I want to help you. To clearly understand your problem I need to quickly ask a few questions. Is that ok with you?" (Note that she won't be happy at all during this encounter. She could be your 'uncooperative' patient.)
5. "Tell me, what do you mean by dizzy?" ("Dizzy means exactly that… dizzy.")
6. "Well, many people describe their problem as 'dizzy' when in reality it's not really 'dizziness'. Anyway, when you get dizzy, do you feel like the room is spinning around you?" ("No.") "Or, do you think that you are spinning inside?" ("Yeah.")
7. "Is your dizziness constant or does it just come and go?" ("Comes and goes.")
8. "When did the dizziness first occur?" ("Two weeks ago.")
9. "How often do you feel dizzy?" ("Once or twice a day.")
10. "How long does it last?" ("One to five minutes.")
11. "Do you have any warning signs that the attack is about to start?" ("No, not really.")
12. "Does it occur at any particular time of the day or night?" ("I'm not sure.").
13. "Does change of motion make you dizzy?" ("I don't know.")
14. "Do you know of any possible cause for your dizziness?" ("I don't know.")

15. "Do you know anything that will stop your dizziness or make it better?" ("No.")
16. "Do you know anything that will make your dizziness worse?" ("No.")
17. "When you get dizzy, do you have a tendency to fall?" ("Yes.") "To which side? Is it to the right or left?" ("I don't remember.")
18. "Have you ever lost consciousness?" ("No.")
19. "Do you have loss of balance when walking?" ("Yeah, sometimes.")
20. "Have you had any headaches when you get dizzy?" ("Yah, light headedness.") "Do you have it now?" ("No.")
21. "Have you had any vomiting when you get dizzy?" ("No.")
22. "Have you had any palpitations?" ("No.") "Shortness of breath?" ("No.") Feelings of panic when you get dizzy?" ("No.")
23. "Have you noticed any difficulty with your hearing?" ("No.")
24. "Do you hear any ringing in your ears?" ("No.")
25. "Do you have any problems with double or blurry vision?" ("No.")
26. "Have you ever noticed any weakness in your arms or legs?" ("No.")
27. "Do you have any numbness in your face, arms, or legs?" ("No.")
28. "Do you have any problems with your bowel movements?" ("No.")
29. "How is your bladder function?" ("Good.")
30. "How has your appetite been lately?" ("Good.")

Past Medical History:

31. "Do you have any other medical problems, other than dizziness?" ("I have low blood pressure.")
32. "Have you had any heart problems?" ("No.")
33. "Have you ever been hospitalized?" ("Yes, for a stroke a few years ago.")
34. "Have you ever had a history of trauma to your head or neck?" ("No.")

Allergies:

35. "Are you allergic to anything?" ("No.")

Medications:

36. "Are you taking any prescription medications now?" ("Yes, aspirin.")
37. "Any over-the-counter medications?" ("No.")

Family History:

38. “Did anybody in your family ever have similar symptoms?”
39. “Does anybody in your family have a history of high blood pressure? Heart disease? Diabetes? Stroke?”

Social History:

40. "Do you smoke?" ("No.")
41. "Do you drink alcohol?" ("Yes, social drinking. One to two beers on weekends.")

Physical Examination:

1. Wash your hands.
2. Perform proper draping techniques.
3. Check for orthostatic hypotension.
4. Do a quick, complete CNS exam, which must include nystagmus, gait, Romberg's test, and cerebellar function tests.

1. Auscultate the neck to check for "carotid bruit."
2. Auscultate the heart.
3. Hearing tests - if you get a positive history of hearing loss
4. Do otoscopic examination if you get any positive history like ear discharge, pain in the ears, ringing in the ears and aural fullness.
5. As long as memory is intact, you don't need to do MMSE and obviously, you don't have time. Always do most important things first.

1. Examine without the gown, not through the gown.

1. People with dizziness are often reluctant to move because of the fear of falling, though they are able to walk. Before you check the gait or perform Romberg's test, say, "I can imagine how uncomfortable it is, but I am here to assist you. I will help you in every aspect of the examination. This won’t take more than a couple of minutes."

Differential diagnosis:

1. Benign positional vertigo
2. TIA

3. Stroke
4. Postural hypotension/Orthostatic hypotension
5. Arrhythmias
6. CNS tumors/Meniere's disease
7. Drug induced/Polypharmacy
8. Nonspecific dizziness
9. Peripheral neuropathy
10. Thyroid abnormalities
11. Anemia
12. Metabolic disturbances, like hypoglycemia

Investigations:

1. CBC with differential
2. Basic metabolic profile (Na, K, Cl, CO_2, BUN, Cr, Calcium and blood sugar)
3. Thyroid function tests
4. Carotid Doppler - if you get a relevant history for stroke/TIA
5. MRI of brain - for suspected acoustic neuroma or any CNS tumor
6. 24 hr Holter monitoring - In patients with h/o palpitations and cardiac disease

2. If you get an uncooperative patient, it will be very difficult to get everything done in 15 minutes. This SP will refuse to cooperate and fail to do all the tests properly. Don't panic. Try to do as much as you can, and remember that they were told to act like that. This problem will be encountered by all the Step 2 CS takers.
3. To be very efficient during the exam, here's what you have to do: practice, practice and practice some more!

Domestic Violance

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1. There are many ways to ask direct questions that can elicit a history of domestic violence or an abusive relationship. It is very important,

however, to always be sensitive and supportive when you encounter cases like these. *No single question is right, as long as you are sensitive and supportive.*

2. In real life, many battered women may hesitate to initiate information about abuse, but are relieved to answer when some one asks. This is why you are expected to recognize these kinds of cases during the step 2 CS exam. You will usually get a patient encounter involving abuse or domestic violence; therefore, it is necessary to know how to ask the key questions, in order to elicit a proper history.

History Taking:

1. If you are suspecting domestic violence or a case of abuse (ex. patient with bruises and/or depression), you can start with a good screening question like this:
    1. "I don't know if this is a problem for you, but because so many people we see are dealing with abusive relationships, I have started to ask about it routinely. Are you currently in a relationship where you are physically hurt, threatened or feel afraid?"
2. If you notice multiple bruises (nice painting by CSA people), and the patient does not give any history of abuse, ask like this:
    1. "I noticed that you have a number of bruises. Did some one do this to you?"
    2. "It looks like someone hurt you. Can you please tell me what happened to you?"
3. If the chief complaint itself is an abuse, you can ask direct questions like:
    1. "What happened? How were you hurt?"
    2. "Was alcohol or drugs involved? How? By whom?" or "Does your partner use drugs or abuse alcohol?"
    3. "Have you ever been attacked with a weapon?"
    4. "How long have you been in this abusive relationship? Has it happened ever before? Are you afraid it will happen again?"
    5. "Has your partner ever made you have sex when you didn't want

to?"

6. "You mentioned that your partner loses his temper with you. How are things between him and your children?"
7. "Have you ever left home? When?" If not: "Have you ever wished you could leave? What has prevented it?"
8. "Are you planning to leave/divorce your partner?"
9. "Has your partner ever threatened or tried to commit suicide?"
10. "Do you, yourself, think of suicide as a way out of the relationship?" If the answer is 'yes,' ask, "Do you have a plan or method by which you would kill yourself or your partner?"
11. "Do you have an emergency plan, if needed?"
12. "Are your family or friends aware of your situation?"

4. During the whole encounter, tell her repeatedly that she does not deserve to be beaten. Battering is against the law.

Physical Examination:

1. Wash your hands.
2. Follow proper draping techniques.
3. Examine the injured parts (painted parts!!).
4. Auscultate the heart and lungs (no percussion necessary, unless patient has a big bruise over the chest or has breathing problems).
5. Auscultate and palpate the abdomen.
6. Examine without the gown, not through the gown.

Counseling:

5. Counseling is a major part of any abuse case in the exam.
6. Assure your patient that you will do everything possible to maintain her safety. Assure her that her medical condition will be treated appropriately, and that she will not be forced to do anything against her will.
7. Tell her that her children will be cared for and kept safe (if present).
8. Assure her confidentiality. Explain to her that only with her signed consent will her medical records be released to any other source.
9. Tell her that violence never ends on its own, and that the violence almost always escalates in severity and frequency over time. Explain

that the only way to end the abuse is to get away from the batterer.

10. Always be respectful and non-judgmental. Say, "I believe you. It's not your fault. You're not crazy and you are not alone. Help is available for you."
11. Before you leave, ask, "Do you think it's safe to go home? Do you have a safe place to stay? Would you like to speak with a domestic violence counselor?"

Case of a Child with Enuresis

1. You will be speaking with the mother of a 5-year-old boy who frequently wets his bed.

History Taking:

1. "Hello Mrs. Jones. My name is Dr XYZ. What brought you in today?" ("Doc, I'm worried about my son. He frequently wets his bed at night.")
2. "Tell me more about it. Has your son ever been dry at night, or has he started wetting his bed after being dry for a long time?" ("I can't really tell. There are times when he doesn't wet his bed").
3. "Does he have any daytime bedwetting?" ("Yes, at times".)
4. "On average, how many nights a week does your child wet his bed?" ("It's actually variable. Maybe 3-4 times")
5. "How many episodes of bedwetting does he have per night?" ("Maybe one or two.")
6. "How much volume of urine does he void during each episode?" ("I'm not sure, but his sheets are always completely soaked.")
7. "Is there a particular time when these episodes occur?" ("I haven't really noticed.")
8. "What is the average quantity of his fluid intake during the day?" ("I'm not sure of the exact quantity, but he does drink a lot of fluids.")
9. "Does he drink excessive amounts of fluid before going to bed?" ("I'm not really aware of that".)
10. "Does he ever have to run to the bathroom?" ("At times.")

11. “How many times in the day does he void urine?” (“Maybe around 7-8 times.”)
12. “What is the quantity of urine during each void?” (“I’m not sure.”)
13. “What is the average length of time between voids?” (“I believe he goes to the bathroom every 2-3 hours.”)
14. “Does he experience any difficulty in initiating or stopping the stream?” (“He hasn’t mentioned that to me.”)
15. “Does he ever complain of dribbling or burning while urinating?” (“No.”)
16. “Does he complain of a feeling of incomplete emptying of bladder?” (“No, he’s never complained of any urinary problems. I might have to ask him specifically.”)
17. “Does he have any problems associated with bowel movements?” (“No, his bowel movements are regular.”)
18. “Mrs. Jones, could you tell me how this problem has affected you & your family?” (“Well, it does cause us a lot of concern.”)
19. “Is there anything you’ve tried so far to deal with this problem?” (“Oh, I’ve tried several things but nothing seems to work.”)

Past Medical History:

1. “Does he have a known diagnosis of diabetes or sickle cell disease?” (“No.”)
2. “Has he ever been given a diagnosis of sleep apnea?” (“No.”)
3. “Does he have any known neurological or gait abnormalities?” (“No.”)
4. “Does he suffer from repeated urinary infections?” (“No.”)
5. “Has he ever undergone any surgery or experienced an injury to his nervous system?” (“No.”)
6. “Did he experience any problems at birth?” (“No.”)

Medications:

1. Is your son currently on any medications? (“No.”)

Family history:

2. “Did you or your husband have problems of bed wetting as a child?” (“No.”)

Social history:

3. “Children often tend to wet the bed as a result of some stressful event in their lives. Are you aware of any incident that could be causing these symptoms in your son?” (“No.)
4. “Would you describe your son as playful and social or shy and quiet?” (“Very playful, doctor.”)

Counseling:

“Mrs. Jones, I’d like to emphasize that bedwetting is a common problem, especially in male children. They usually do not have any control over this. Bedwetting does not indicate mental problems, but it can be extremely stressful and embarrassing for children if they continue to wet their bed beyond the age of 3. As a result, they may lose self-confidence and avoid social situations like sleepovers at their friend’s houses. Your role as a parent is to be supportive, and to help your child deal with the problem. Here’s what you can do:

1. Monitor your child’s fluid intake during the day.
2. Limit the amount of fluid he takes 2 hours before he goes to bed. (ideally should not be more than 2 ounces)
3. Encourage your child to go to the bathroom before going to bed.
4. Have your child change his pajamas and the bed sheet if he wets them at night. It is also helpful to have a rubber-flannel sheet handy to cover over his wet sheet.
5. Another helpful step is to set an alarm clock and have him wake up 2-3 hours after he goes to bed. He can then go to the bathroom to void urine.
6. Bed-wetting alarms are excellent options for children older than 5 years. An alarm is attached to the child’s underwear, and the first drop of urine triggers off the alarm. The child then wakes up and goes to the bathroom to finish urinating. With time, the child learns to habitually wake up to go to the bathroom when his bladder is full.
1. Motivate your child to be involved, and reward him when he’s successful.”

Differential Diagnosis:

1. Primary enuresis
2. Secondary enuresis

Investigations:

1. U/A

Case of a 70 yo F Complaining of Forgetfulness

Vital Signs:

1. BP 150/85 mm Hg
2. Pulse 76/min, regular
3. RR 16/min
4. T 36.1C(97F)

History Taking:

1. Hello, Mrs. Thomson. I am Dr. Jones. How are you doing today?
2. How have you been feeling lately? Are you feeling sad or lonely?
3. Are you having any problems with your memory?
4. Do you have any problems sleeping?
5. Tell me about your typical diet. What do you eat?
6. Do you have any problem eating or making meals for yourself?
7. Do you have difficulty walking?
8. Do you have any trouble with your toiletry habits?
9. Do have any problems getting your shopping and housekeeping done?
10. Are you able to find your way through your house?
11. Do you have any problem driving to the grocery store?
12. Do you have any difficulty managing your accounts?
13. How are your bowel habits?
14. Have you noticed any weight loss over the past few months?
15. Do you have any dizzy spells?
16. Did you ever feel that your heart was pounding?
17. Have you noticed any cold or heat intolerance?
18. Do you have somebody to take care of you, in case of an emergency? If not, would you like me to get you in touch with a social organization that would be happy to help you?

Past Medical History:

19. Did you have any medical problems in the past?

Family History:

20. Do you have any family members who had a hereditary medical condition?

Social History:

21. Do you smoke?
22. Do you drink any type of alcoholic beverages?
23. Have you ever had any sexually transmitted diseases?

Medications:

24. "Are you taking any prescription medications now?"

Physical Examination:

1. Ask the following as part of the mental status exam:
    1. Mrs. Thomson, can you tell me what your full name is?
    2. Can you tell me what day it is today?
    3. Can you tell me where we are now?
    4. Spell the word 'WORLD' backwards for me.
    5. I'm going to say three words. As soon as I'm finished, please repeat the three words I said. We will talk for a while, then I'll ask you to repeat those three words again.
    6. Please put your left hand on your right hand. Bring both hands towards your chest, and then back to their original position.
2. Wash your hands.
3. Perform proper draping techniques.
4. Do an ophthalmoscopic examination.
5. Do a focused neurological exam.
6. Do a fast heart and lung exam.
7. Do the 'Get Up and Go' test.
8. Examine without the gown, not through the gown.

Counseling:

1. Tell her the diagnostic possibilities, necessary workup, and prognosis.

2. If you suspect Alzheimer's, talk with the patient about it. Stress the importance of a structured home environment, and the precautions that need to be taken to avoid falls.
3. Explain the necessity of taking her medication regularly.
4. Make sure the patient understands her problem.
5. Ask her about her social support and offer any help, if needed.

Differential Diagnosis:

1. Alzheimer's Disease
2. Vascular dementia
3. Normal pressure hydrocephalus
4. Vitamin B12 deficiency
5. Hypothyroidism
6. Masked depression
1. Chronic subdural hematoma

Investigations:

1. CBC with differential
2. CT scan of the head
3. Serum TSH and Vitamin B 12 level
4. Basic metabolic panel (Na, K, Cl, CO_2, BUN, Creatinine, Calcium)
5. Syphilis serology

Case of a 27 yo WF complaining of a Headache

Vital Signs:

1. BP 120/70 mm Hg
2. T 98.6 F
3. RR 19/min
4. HR 80/min

Simulated encounter:

Knock on the door:

History Taking:

1. "Good morning, Mrs. Jamie. My name is Dr. XYZ. How are you doing today? What brought you in today?"("Doc, I have a headache.")
2. "Can you tell me a little bit more about your headache?"("Doc, my head hurts so much.")
3. "How long have you had your headache?"("For several hours.")
4. "How did the pain start? I mean, was it all of a sudden or gradual?"("It started suddenly.")
5. "Is it a constant or intermittent type of pain?" ("It's pretty much constant.")
6. "Can you please show me exactly where the pain is?" ("All over my forehead.")
7. "Does it hurt anywhere else? Like your jaw or the back of your neck?" ("No.")
8. "What were you doing before you noticed the headache?" ("I was in my office.")
9. "How do you describe your pain?" ("It's a band-like sensation.")
10. "On a scale of 1 to 10, which number would best describe your pain?" ("I would say probably between 7-8.")
11. "Is there anything that relieves your pain?" ("Yes, staying in a dark room.")
12. "Is there anything that makes it hurt more?" ("Yes, bright light and moving around.")
13. "Have you felt nauseated or been vomiting? ("I've been a little bit nauseated, but I haven't thrown up.")
14. "Have you ever had this type of pain before?" ("Yes, a couple of times about three months ago.")
15. "You said you've had headaches like this before. When you get these headaches, how long do they last?" ("I think they last for an hour. I'm not sure.")
16. "Do you have any warning signs before they come? For example, do you get blurry vision or do you see flashes before the headache?" (Ask the premonitory symptoms) ("No, I have no prior warning. They just hit me like a ton of bricks.")

17. "Do you have any blurriness or double vision now?" ("No.")
18. "Are these episodic headaches affecting your daily activities?" ("No, I'm working as usual.")

Review of Systems: (For the exam, make the ROS very focused.)

1. "Ok, let me quickly ask you some other questions:"
2. "Do you have any fever?" ("No.") "Chills?" ("No.")
3. "Is your neck stiff?" ("No.")
4. "Have your eyes been watery?" ("No.")
5. "Have you had a runny nose?" ("No.")
6. "Have you noticed any ear discharge?" ("No.")
7. "Have you had any head trauma?" ("No.")
8. "Have you had any weakness in your arms or legs?" ("No.")
9. "Have you noticed any sensory changes, like tingling or numbness in your hands or legs?" ("No.")
10. "Do you have any urinary complaints?" ("No.")
11. "Do you have any problems with your bowel movements?" ("No.")
12. "Has there been any change in your appetite?" ("No.")
13. "Have you lost or gained weight lately?" ("No.")

Past Medical History:

1. "Do you have any other medical problems?" ("No.")
2. "Do you have a history of high blood pressure?" ("No.")
3. "Have you ever been hospitalized before?" ("No.")

Allergies:

1. "Are you allergic to anything?" ("No.")

Medications:

2. "Are you taking any prescription or over-the-counter medications?" ("Yes, Tylenol.")
3. "Have you ever taken recreational drugs?" ("No.")
4. "Do you use any hormonal contraception?" ("No.")

Family History:

1. "Can you please tell me something about the health of your family

members?" ("They are fine.")

2. "Does anyone in the family have habitual headaches?" ("Yes, actually my sister has migraines. She wanted me to see you. She thinks my headaches might be migraines, also. What do you think?") "Ms. Jamie, from what you just told me, there is a possibility that they might be migraine headaches. But, I need to ask a few more questions, and then give you a physical examination. That will help me better determine what the problem is. Is that okay with you?" ("Sure, doc.")

Social History:

1. "What do you do for a living? Where do you work?" (“I’m a sales clerk. I work in the mall.”)
2. "Do you feel any stress at work or home? Are you stressed out about anything?" (“Not really.”)
3. "Do you smoke?" ("No.")
4. "Have you ever smoked?" ("No.")
5. "Do you drink alcohol? How much and how often?" (“Yeah. I guess around 1-2 beers a month.”)
6. "Are you sexually active? Are there any problems in your sexual life?" (“No.”)

Physical examination:

1. Wash your hands.
2. Perform proper draping techniques.
1. Auscultate the neck to check for a carotid bruit.
2. Palpate the head, neck, and shoulder regions.
3. Check the temporal arteries in elderly patients.
4. Examine the spine and neck muscles.
5. Do a functional neurological examination including:
    1. cranial nerve examination
    2. ophthalmoscopic and otoscopic examination
    3. assessment of sensation, muscle strength, and reflexes
    4. cerebellar (coordination) tests
    5. tandem gait

6. Romberg test

6. Examine without the gown, not through the gown.

Counseling:

1. Call the patient by her name.
2. Tell her the possible diagnosis and need for further workup.
3. Acknowledge the discomfort of the patient.

Differential Diagnosis:

1. Migraine
2. Cluster headache
3. Tension headache
4. Subarachnoid hemorrhage/CVA
5. Sinusitis
6. Brain tumor
7. Meningitis/Encephalitis/Infections
8. Temporal arteritis (in the elderly patients)
9. Refractive errors (if they give any positive history and PE)
10. Medications/Drugs

Investigations:

1. CBC with differential
2. ESR
3. Temporal artery biopsy (in elderly patients)
4. Sinus X-ray
5. CT head without contrast
6. LP (Not in this patient. If the patient appears sick and presents with fever or confusion, you should also take blood cultures for suspected meningitis.)

HeelpainCase

Case of Heel/Foot pain

History Taking:

1. What brings you in today?
2. Where exactly do you feel the pain?
3. On a scale of 1 to 10, with 10 being the worst, how would you rate the severity of your pain?
4. How would you describe the quality of the pain?
5. When did this pain begin?
6. How long does an episode of pain last?
7. When you get the heel/foot pain, do you feel pain in any other part of your body?
8. What makes the pain worse?
    1. Walking?
    2. Standing? After standing, how long does it take for the pain to start?
9. Does anything make the pain better?
10. Did you ever experience this before? When? How long would an episode last? How frequent would they occur?
11. Did you ever have any accidents/trauma involving your foot/heel?
12. Do you have fever?
13. Do you have joint pains? Where?
14. Did you ever have morning stiffness?
15. Did you ever have a history of (h/o) diarrhea or any acute illness? (for possible reactive arthritis)
16. Did you ever have any urethral discharge? How about an eye infection/conjunctivitis? (for possible Reiter's syndrome)
17. Did you ever get any rashes? (For psoriatic arthritis)
18. What type of work do you do?
19. Does your work involve any prolonged standing?
20. Do you have to walk a lot at your work?

Past Medical History:

1. Do you have any other medical problems?

Allergies:

21. Do you have any allergies?

Medications:

22. Are you currently taking other medications?

Family History:

23. Does anybody in your family have a history of rheumatoid arthritis? How about any other joint diseases?

Social History:

24. Do you smoke?
25. Do you drink alcoholic beverages?
26. Have you ever used recreational or illicit drugs?
27. Are you currently sexually active? Do you use any form of contraception? Did you ever have a sexually transmitted disease?

Physical Examination:

1. Wash your hands.
2. Perform the proper draping technique.
3. Check the eyes for possible conjunctivitis. (if you suspect Reiter's syndrome)
4. Inspect the foot. (let the SP know that you are inspecting)
5. Palpation of the entire foot (not just the heel) for any point of tenderness.
6. Check for the range of motion of the ankle & forefoot joints. Check for pain and restriction of movements.
7. Ask the patient to do active dorsiflexion and plantar flexion. Check for any tendon tenderness. (for tendonitis)
8. Examine without the gown, not through the gown.

Counseling:

Before closing the encounter, you may counsel the SP like this:

"I have to order an x-ray of your foot and ankle and some basic blood tests before we come to a proper diagnosis. Meanwhile, I will try to help you get relief for your pain.

2. Rest your foot for two or three days.
3. Ice it for 30 minutes. Do this every four hours.

4. Use soft heel pads.
5. Avoid excess weight on your heel.
6. Try over-the-counter ibuprofen for pain relief.
7. You can also try using a padded foot splint. (These splints are available in pharmacies that feature orthopedic supplies.)

Most of the time people will get better with these measures. If you don't get better, or if your tests show abnormal results, we will sit together and discuss the other possible options. Is that okay with you?" ("Sounds great, Doc.")

Investigations:

1. CBC with differential
2. ESR
3. X-ray of foot and ankle, 3 views
4. Rheumatoid factor assay

Differential diagnosis:

1. Plantar fasciitis
2. Calcaneal periostitis
3. Calcaneal spurs
4. Painful heel pad syndrome
5. Bone tumors
6. Rheumatoid arthritis
7. Reiter's syndrome

Case of a 45 yo M with Hemoptysis

History Taking:

1. Good morning, Mrs. Reeves. I am Dr. Lopez. What brings you in today?
2. When did it happen?
3. How many times?
4. Was it bright red blood or streaked with sputum? Or rust-colored

sputum?

5. How much was it?
6. Do you have cough? Is it a productive cough? Is it foul-smelling sputum?
7. Do you have any breathing problems?
8. Have you had any chest pain?
9. Have you had fevers? Chills? Night sweats?
10. Have you lost any weight?
11. How is your appetite?
12. Have you had contact with a tuberculosis patient?
13. Did you travel to any country?
14. Have you had multiple sexual partners?

Past Medical History:

1. Do you have any other medical problems? (HIV, tuberculosis, recurrent pneumonia)

Social History:

1. What do you do for a living?
2. Do you smoke?
3. Do you drink alcohol?
4. Do you use IV drugs?

Family History:

1. Do you have any family history of lung cancer?

Allergies:

1. Are you allergic to any medication?

Medications:

1. What medications do you use on a regular basis?

Examination:

1. Wash your hands.
2. Perform proper draping techniques.
3. Examine the oral cavity.
4. Check for cervical lymph nodes.
5. Percuss the lungs.
6. Palpate the lungs. (Tactile Vocal Fremitus/TVF)
7. Auscultate the lungs.

8. Auscultate the heart.
9. Palpate the abdomen.
10. Check for finger clubbing.
11. Examine the skin for any evidence of vasculitis.
12. Examine the legs for deep vein thrombosis, as needed.
13. Examine without the gown, not through the gown.

Differential Diagnosis:

1. Bronchiectasis
2. Acute or chronic bronchitis
3. Pneumonia
4. Bronchogenic carcinoma
5. Lung abscess
6. Tuberculosis
7. Connective tissue diseases (Wegener's disease, Goodpasture's, Lupus)
8. Pulmonary embolism
9. Pseudo hemoptysis (Hematemesis)

Investigations:

1. CBC with differential, ESR
2. PT/INR/PTT
3. Sputum for AFB and gram stain
4. Chest x-ray
5. PPD, as needed
6. Urinalysis
7. BUN and Creatinine
8. CT of the chest, as needed, for bronchiectasis

Case of Insomnia

1. Insomnia is one of the most common problems in the USA; therefore, it is worthwhile to study this case for the Step 2 CS.
2. Insomnia has numerous - and often concurrent - etiologies, including medical conditions, medications, psychiatric disorders, and poor sleep

hygiene. Sleep apnea should also be considered in the differential diagnosis.

3. The evaluation usually requires detailed history taking in order to narrow down your differential diagnosis.

History Taking:

1. "What brought you in today?" ("I have problem with sleep, Doc.")
2. "Can you please tell me more about your problem?" ("I used to work as a truck driver during the night and now I switched to daytime work. Since then, I am having problems with sleep. I think this all is due to the shift work. Please give me some sleeping pills, Doc.")
3. "I understand that your problem might be due to your change of working schedule. However, there are some other common things and conditions that can cause sleep problems. Most can be easily treated, if found. So, I need to ask a few more questions about your sleep patterns, your general condition, and some other things. Is that ok with you?" ("Sure, go ahead Doc.")
4. "How long have you been having problems with sleep?" ("Around three-four weeks.")
5. "Do you have problems falling asleep? ("Yeah, most of the times.")
6. "Do you have any problems staying asleep? ("Yeah, some times.")
7. "Do you have problems with waking in your sleep?" ("No.")
8. “You said that most of the times you are having problems with falling asleep.”
    1. “When do you usually go to bed?" ("Between 8 - 9 PM")
    2. "How much time does it take you to fall asleep?" ("1 to 2 hours")
    3. "What do you do before you go to bed? I mean, some people do exercise in the late evening and drink alcohol before going to bed. Do you do any exercise like that?" ("No.")
    4. "Do you drink any alcohol before you go to bed?" ("Yeah.") "How much do you drink?" ("A couple of beers, usually.")
    5. "Do you smoke before you go to bed?" ("Yah, mostly after having dinner.")
    6. "Do you drink caffeine or excess coffee before you go to bed?" ("Not really.")

9. "Do you watch television while lying on the bed?" ("Yeah, usually.")
10. You said you also have some problems staying asleep."
    1. “Do you wake up several times during the night?" ("Not several, but 2-3 times, and if I wake up, it takes awhile to get back to sleep again.").
    2. "Okay, you said you wake up 2-3 times in a night. Do you have any idea what might be causing it?”
    3. “I mean, do you wake up often to urinate? ” ("No.")
    4. “Do you experience any problems with breathing?” ("No.") “Coughing?" ("No.")

1. If you are asking several questions, always pause after each question.

11. "Have you or any of your family members noticed that your sleep is restless, or that you move around a lot in your sleep?" ("No, not that I know of.")
12. "Do you have pain anywhere?" ("No.")
13. "How is your mood?" ("Pretty good.") (If the SP appears depressed, you have to ask all depression questions. It is very unlikely to get a case with 2-3 problems like depression, shift in work, etc., since it would be very difficult to manage in 15 minutes.)
14. "How are your bowel habits?" ("Pretty good.")
15. "How is your bladder function?" ("Pretty good.")

1. Sometimes the major cause of sleep disturbance in middle-aged women is the menopause-related "hot flush". Recent studies indicate that nearly every hot flash promotes an arousal from sleep. So, please keep this in mind if you get a female patient of menopausal age.

Past Medical History:

16. "Do you have any other medical problems?" ("No, I’m pretty healthy.")
17. "Have you ever been hospitalized for any reason?" ("No, never.")

Allergies:

18. "Do you have any allergies?" ("No.")

Medications:

19. "Are you taking any prescription medications?" ("No.")

20. "Any over-the-counter medications?" ("No.")
21. "Are you using any recreation type drugs?" ("No.")

Social History:

22. "You said you have a habit of smoking and drinking alcohol."
    1. "How long have you been smoking?" ("15 yrs.")
    2. "How many cigarettes do you smoke in a day?" ("5-10.")
    3. "How long have you been drinking alcohol?" ("Same as smoking.")
    4. "How much do you drink per day?" ("About 2-3 beers a day.")
23. "Are you sexually active?" ("Yes.") "Do you have any problems with sexual performance?" ("No.")
24. "Is your work stressful?" ("No.")

Family History:

25. Does anybody in your family have the same symptoms?

Physical Examination:

1. Wash your hands.
2. Perform the proper draping technique.
3. Check the thyroid.
4. Auscultate the lungs and heart quickly.
5. Examine without the gown, not through the gown.

Counseling:

1. "Based on your history I think your problem is most likely due to multiple factors.
    1. Obviously, your shift work plays a big role in your sleep pattern, as there is no consistency in your schedule. I would like you to maintain a sleep diary for two weeks to record your sleep patterns. Please keep regular bedtimes and wake times, even on weekends and days off from work.
    2. Limit or stop the use of nicotine, caffeine, and alcohol.
    3. Exercise regularly, but no later than late afternoon or early evening.
    4. Do not use the bed as a place to worry, especially about not

sleeping. If you feel it's necessary, write down all your worries and concerns before you go to bed, and place the list on your dresser to examine it the next morning.

5. Use the bedroom only for sleep. Don't read, watch television, eat, or do other activities in bed.
6. Try to avoid daytime naps. But, if you must nap, do so in the early afternoon and for no longer than 30 minutes per day.
7. Eat a light snack before bedtime if food is needed because of hunger.
8. Get regular exposure to outdoor sunlight, especially in the late afternoon.

1. If you follow these guidelines, your sleep problems may be eliminated. We usually don't recommend medication for insomnia, as this problem often resolves itself with behavioral modifications. Okay?"
2. "Do you have any questions?"

Diagnosis:

1. Circadian rhythm sleep disorder

1. **Discussion of insomnia:**
    1. Certain medical conditions, such as COPD, GERD, peptic ulcer disease, BPH (resulting in overflow incontinence), and congestive heart failure with associated paroxysmal nocturnal dyspnea, frequently disturb sleep, and may be interpreted by the patient as insomnia.
    2. Patients with chronic pain, such as that resulting from chronic pain syndromes, fibromyalgia, and cancer, may have insomnia and early-morning awakening. (Remember: The SP won't tell you about any associated pain unless you ask.)
    3. A psychiatric disorder, such as depression, is frequently a cause of chronic insomnia, especially in the elderly.
    4. Periodic leg movements during sleep are common in persons over 65 years of age. Although these limb movements are often associated with brief arousals, many patients have no sleep symptoms.
    5. Regardless of the cause of insomnia, most patients benefit from behavioral approaches that focus on good sleep habits. Exposure to

bright light at appropriate times can help realign the circadian rhythm in patients whose sleep-wake cycle has shifted to undesirable times.

6. Chronic insomnia may reflect a disturbance in the normal circadian sleep-wake rhythm, as in this patient.

Menopause Case

Case of a 52 yo F complaining of Hot Flashes

Vital Signs:

1. BP 140/80 mm Hg
2. Pulse 80/min, regular
3. RR 16/min
4. T 98.8^{o}F

History Taking:

1. "Hello Mrs. Armstrong; I am Dr. Jones" ("Hello, Dr.") "Good morning." ("Good morning, Dr.") "Nice to meet you." ("Nice to meet you too.")
2. "What brings you in today?" ("I keep having hot flashes and they're driving me crazy.")
3. "When did they start?" ("Around three months ago.")
4. "How often do they happen?" ("About 10 times a day.")
5. "Do you feel anything else when these flashes occur?" ("I sweat a lot and I feel my heart racing.")
6. "Do you have any warning beforehand? I mean do you feel it coming on before it really starts?" ("Yes Dr., I do. It sometimes even disturbs my sleep.")
7. "How do you feel on most days? How has your mood been the last three months?" ("I don't know Dr. I feel dull, sometimes I can't control my temper, and most of the time I just want to be left alone. I don't feel on top of things. This whole thing is driving my husband crazy.")
8. "Do you feel any burning or pain when urinating?" ("Yes, I do. I find that I have to rush to the bathroom both day and night.")
9. "When did you have your last menstrual period, Mrs. Armstrong?"

("About a year ago.")

10. "Do you have any problems with your bowels?" ("No")
11. "Have you had any thyroid problems in the past?" ("Yes Dr., I had a goiter 10 years ago but it was surgically removed.")
12. "Do you have any other problems like high blood pressure or diabetes?" ("No.")
13. Make eye contact and then say, "Mrs. Armstrong, I'm going to ask you some sensitive questions. It might be embarrassing to you, but it's for your best interest."
14. "How has your sexual life been lately?" ("I don't know, Dr. I get a lot of burning sensation and I generally don't show much interest because of the pain, even though my husband wants to do it.")
15. "Is he supportive?" ("Yeah, I guess, but he is frustrated with the way I have been behaving.")
16. "Have your arms and legs ever been swollen and painful?" ("No.")
17. "Have you had any blood clots in your legs?" ("No.")
18. "Have you ever had any pain in the legs or back (for osteoporosis)?" ("No.")

Past Medical History:

19. "Do you have any other problems for which you've needed counseling or medication?" ("No, Dr. This is the first time that I've been sick.")

Social History:

20. "Do you smoke?" ("No.")
21. "Do you drink any type of alcoholic beverage?" ("No.")

Allergies:

22. "Do you have any allergies?" ("No.")

Family History:

23. "Do any of your family members have a history of clotting disorders?" ("No.")
24. "Have any of your relatives been diagnosed with breast or uterine cancer?" ("Yes, Dr. My sister had one breast removed.")

Physical Examination:

1. Wash your hands.
2. Perform the proper draping technique.
1. Do a heart, lung, and abdominal exam very quickly and superficially.
2. Check for muscle pain in the back.
3. Check for hyperactive reflexes.
4. Palpate the neck. (thyroid and lymph nodes)
5. Examine without the gown, not through the gown.

Counseling:

1. Tell the patient that the most probable diagnosis is menopause.
2. Offer help to educate the husband about the possible diagnosis.
3. Tell her about the risks and benefits of hormone replacement therapy (HRT).
4. Offer her estrogen cream for the vagina, to ease her dyspareunia and her dysuria.
5. Inform her that she needs to supplement calcium in her diet to reduce the risk of osteoporosis. Inform her of the beneficial effect of adequate weight bearing exercise.

Differential Diagnosis:

1. Menopause
2. Hyperthyroidism
3. Occult malignancy
4. Factitious disorder
5. Chronic fatigue syndrome

Investigations:

1. CBC with differential
2. Serum TSH
3. Serum FSH and LH (only in some doubtful cases)
4. Pap smear (yearly)
5. Screening mammogram
6. Annual FOBT

Other Important Cases

1. Upper extremity pain

1. In the history, just follow LIQOR AAA and PAM HUGS FOSS.
2. Consider these issues during your history taking:
    1. Carpal tunnel syndrome (ask about the occupation)
    2. Cervical spondylitis
    3. Herniated cervical disc
    4. Thoracic outlet syndrome (ask whether the symptoms worsen with the above head activities, like combing)
    5. Tenosynovitis
    6. Trauma
    7. Referred pain from coronary ischemia

Physical Examination:

1. Wash your hands.
2. Check the thyroid gland.
3. Check the neck movements and the range of motion.
4. Do thoracic outlet test. (Adson's test)
    1. Ask him to take a deep breath. Extend the neck and turn the chin towards the opposite side.
    2. Repeat the test with the chin on the opposite side.
    3. In the presence of thoracic outlet syndrome, the radial pulse will disappear.
2. Do Phalen's test (for carpal tunnel syndrome)
    1. Hold the patient’s wrists in acute flexion for 30-60 seconds.
    2. Patient will complain of pain, numbness, and tingling over the distribution of medial nerve, if the test is positive.
1. You can also elicit Tinel's sign, if you want.
    1. With your finger, percuss over the course of the medial nerve in the carpal tunnel.

    2. Patient will complain of pain, numbness, and tingling over the distribution of the medial nerve, if the test is positive.
2. Check sensations, muscle strength, and reflexes of both upper extremities.

Investigations:

1. CBC with differential, ESR
2. EMG and nerve conduction studies
3. X-ray of the cervical and thoracic spine
4. ECG
5. MRI of the spine

2. A 34 yo F who came for a bronchial asthma drug refill

1. This case is not that important, but there is always the possibility that you may encounter this in the step 2 CS, so just take a look.

1. Start with a formal greeting. Ask open-ended questions like, "What brought you in today?"
2. The things that you need to ask specifically for this case are:
    1. "Can you please tell me more about your asthma? When were you diagnosed for the first time? How have you been doing since then?"
    2. "Can you please tell me about your current medications?" or "What medications are you on?"
    3. "Did you notice any problems or side effects with your medications?"
    4. "Do you have any trouble breathing during the day or night with regular activity?"
    5. "How often does this occur on a weekly basis?"
    6. "Do you have any trouble breathing with exercise?"
    7. "How often does this occur on a weekly basis?"
    8. "Do you have episodes of excessive coughing during the day or night time?"
    9. "How often does this occur on a weekly basis?"
    10. "Have you ever been admitted to the hospital for an acute or severe attack?"
    1. "Tell me, what do you think about the severity of your asthma?

Do you think it is getting better or worse?"

2. "Do you know what precipitates your asthma?"
3. "Are you taking any precautions to avoid those?"

2. After this you, will just have to follow PAM HUGS FOSS. Make sure you ask about her smoking history, and talk about the importance of smoking cessation.

Physical Examination:

1. The PE basically requires:
    1. an HEENT exam to look for any sinus tenderness (sinusitis), or signs of upper respiratory tract infection, which can aggravate or precipitate asthma.
    2. a complete lung examination
    3. looking for JVD and pedal edema (for signs of cor pulmonale, even though it is a very rare complication of asthma)

Investigations:

2. Spirometry or pulmonary function tests are usually not required, unless the patient is elderly and having persistent asthma.
3. For chronic, persistent, and refractory asthma, request:
    1. CBC with differential
    2. Aspergillus serology
    3. Chest x-ray
    4. X-ray of paranasal sinuses
    5. 24 hour pH for GERD
    6. Skin tests

1. Differential diagnosis for chronic, persistent asthma in a smoker includes:

1. Bronchial asthma
2. Chronic obstructive pulmonary disease
3. Bronchopulmonary aspergillosis
4. Sinusitis
5. Atypical GERD

Case of a 22 yo M African American with Night Sweats

History Taking:

1. How long have you had night sweats?
2. Have you had any fevers or chills?
3. Have you lost any weight unintentionally?
4. Do you have any weakness or fatigue?
5. Do you have itching? (pruritus)
6. Do you have pain anywhere? (back pain and fever suggest osteomyelitis)
7. Do you have a cough?
8. Do you have any breathing problems?
9. Have you had any headaches?
10. Have you had any palpitations? (racing or pounding heart beat)
11. Have you had any diarrhea?
12. Do you have problems adjusting to temperatures (heat intolerance)?

Past Medical History:

1. Do you have any other medical problems?
2. Have you ever been tested for tuberculosis with PPD?
3. Have you had any exposure to a tuberculosis patient?

Social History:

1. What do you do for a living?
2. Do you smoke?
3. Do you drink alcohol?
4. Have you used any recreational or illicit drugs?
5. Do you have multiple sexual partners? Do you use condoms?

Family History:

1. Is there a family history of cancer or thyroid problems?

Medications:

1. Are you currently using any medications, including over-the-counter

drugs?

Allergies:

1. Are you allergic to any medication?

Physical Examination:

1. Wash your hands.
2. Perform the proper draping techniques.
3. Examine all lymph nodes.
4. Examine eyes for lid lag or exophthalmos.
5. Examine oral cavity for thrush.
6. Check for hand tremors.
7. Examine the skin (peripheral stigmata of infective endocarditis).
8. Auscultate the lungs.
9. Auscultate the heart.
10. Examine the abdomen for hepatomegaly and splenomegaly.
11. Examine without the gown, not through the gown.

Differential Diagnosis:

1. Malignancy (lymphoma, solid tumors)
2. Infections (tuberculosis, HIV, endocarditis)
3. Endocrine disorders (hyperthyroidism, pheochromocytoma)
1. Medications (antidepressants, cholinergic agonists, hypoglycemic agents)

Investigations:

1. CBC with differential
2. ESR
3. Blood cultures
4. Chest x-ray and PPD
5. TSH
6. ELISA for HIV, as needed
7. CT scan of the chest and abdomen for lymphoma, as needed

Case of Obesity

Doorway information

A 40 yr old white female (Mrs. Kelly) came for obesity evaluation

Vital Signs:

1. BP 150/90 mm Hg
2. HR 68/min
3. RR 16/min
4. T 36.7C(98F)

History Taking:

1. How do you approach this patient?

1. This is a quick glance of questions that you have to ask in a case of obesity. Don't forget to use appropriate transition sentences and open-ended questions.

1. Knock on the door and enter the room with a smiling face.
    1. "Hello Mrs. Kelly, I am Dr. Robert Walker. Good morning. Nice to meet you." ("Nice to meet you, doctor.")
    2. "How are you doing today?" ("Good.")
    3. "Excellent. So, what brings you in today?" ("You know doctor, I am really worried about my weight. I just keep gaining, more and more.")
    4. "I am glad that you came here for an evaluation. We will work together and try to fix it, okay?" ("Yes doctor, thank you.")
    5. "I know you are concerned about your weight gain. Would you please describe to me a little bit more about your problem?" ("I don't know anything specific doctor, but I am concerned about my weight.")

1. Remember, the SPs reveal only a few things. They really won't tell you until you ask specific questions. Before you ask, make a mental checklist of problems associated with obesity.

2. Here are the common problems associated with obesity:
    1. Type II diabetes
    2. Heart disease
    3. Stroke
    4. Hypertension
    5. Osteoarthritis
    6. Sleep apnea

7. Breathing problems
8. High cholesterol
9. Gall bladder disease
10. Increased incidence of cancer like endometrial, colon, postmenopausal breast cancer, etc.
11. Menstrual irregularities
12. Stress incontinence (due to weak pelvic floor muscles)
13. Psychological disorders like depression
14. Psychosocial difficulties like social stigmatization

1. How do you ask all of these?
    1. "Mrs. Kelly, I am going to ask a few specific questions about your present and past medical health. Just let me know if you have any problems. Okay?" ("Oh sure, Doc.")
    2. "How long have you really been concerned about your weight gain?" ("Maybe for the past 6-7 months.")
    3. "What do you think is the major reason for your obesity?" ("I really don't know.")
    4. "How is your appetite?" ("It's too much, Doc. I want to stop eating junk food, but I can't control myself.")
    5. "How long have you been having this increased appetite?" ("For the last 2-3 years.")
    6. "Can you describe to me more about your diet? What does it usually consist of?" ("Pretty much cheese and junk food doctor, some times fruit.")
    7. "How is your mood, Mrs. Kelly? Are you feeling okay?" ("I am feeling a little bit down these days.")
    8. "Do you have any problems with your breathing, especially at night?" ("No.")
    9. "How is your urination?" ("Pretty good.") "I mean, have you noticed any increased frequency?" ("No.") "Have you ever leaked without your knowledge?" ("No")
    1. "Do you have any problem with your bowel movements?" ("They are pretty regular.")
1. You have to consider hypothyroidism and Cushing's syndrome in your

differential diagnosis for a case of obesity.

1. "Have you ever had any problems adjusting to temperatures?" ("No.")
2. "Have you ever been on any steroid medications for any reason?" ("No.")

1. You already know that she did not have any problems with bowel movements. (constipation in hypothyroidism)
    1. "Did you notice any joint pain, especially at the level of the hips or knees?" ("Some pain in both knees.")

Past Medical History:

2. "Have you ever been diagnosed with high blood pressure?" ("No.")
3. "When was your last visit with your primary care physician?" ("A couple of years ago.")
4. "Have you ever had any heart problems?" ("No.")
5. "Have you ever been tested for diabetes?" ("No.")
6. "Okay Mrs. Kelly, when was the last time your cholesterol level was checked?" ("I think five years ago. It was slightly elevated, so I did some exercises. They didn't really help much.")
7. "Have you had any surgeries in the past?" ("Yes Doc, cholecystectomy nine months ago.")

Allergies:

8. "Are you allergic to anything?" ("No.")

Medications:

9. "Are you taking any prescription medications?" ("No.")
10. "Do you take any over-the-counter medications?" ("No.")

Sexual History:

11. "Okay Mrs. Kelly, now I would like to ask you a few personal questions. Everything you say will be kept confidential." ("Okay Doc, sure.")
12. "How has your menstrual cycle been?" ("They have become irregular these days, but they are not bothering me much.")
13. "How long have you been having these irregular periods?" ("For the past 2-3 years. Seems like everything started then.")
14. "When was your last menstrual period?" ("20 days ago.")

15. "Are you sexually active?" ("This is one more problem for me doctor. These days I don't feel like having sex.")

Social History:

16. "Do you smoke, Mrs. Kelly?" ("No.")
17. "Do you drink any type of alcoholic beverages?" ("Occasionally, 1-2 beers on the weekend.")
18. "Have you ever used recreational drugs?" ("No.")
19. "What do you do for a living?" or "Do you work?" ("Yes doc, I am working as a desk clerk.")

Physical Examination:

1. Wash your hands.
2. Perform the proper draping techniques.
3. Just do some focused lung and heart examination.
4. Check the thyroid gland.
5. Check extremities for any edema.
6. Examine without the gown, not through the gown.

Counseling:

2. "There is a possibility of a thyroid problem (even Cushing's syndrome, if the patient is on steroids) in your case, although it is very unlikely. First, let me run some tests on you. Then, we will sit together and go over the treatment options available."
3. "Meanwhile, try to restrict fatty foods and start regular exercise."
4. "Most people will not succeed if they radically change their current eating and cooking habits. However, you will probably have greater success if you try to modify only one aspect of your eating habits at a time. Eventually, you will find yourself eating a healthier diet."
5. "If you would like more specific advice for diet changes, there are many excellent books available, or you may wish to ask for a formal consult with a dietitian."

Differential Diagnosis:

6. Obesity
7. Hypothyroidism

8. Cushing's syndrome

Investigations:

2. CBC with differential
3. Fasting blood sugar
4. Serum TSH
5. Urine cortisol levels
6. Fasting lipid profile
7. Consider annual PAP smear

Case of a Patient with Palpitations

History Taking:

1. Start with a formal greeting and introduce yourself.
    1. "What brought you in today?" (I am having palpitations.)
    2. "Can you please describe exactly what you mean by palpitations?" (My heart is pounding.)
    3. "Do you get any other symptoms other than the palpitations?"
    4. "When was the first time you noticed them?"
    5. "Do they occur continuously or intermittently?"
    6. "Are they regular or irregular?"
1. Tap on the table and show the patient the difference between regular and irregular beats. Ask him to demonstrate/tell exactly what he's feeling.
    1. "How long do they last?"
    2. "Approximately how many times do you notice them a day? Has there been a change recently?"
    3. "Have you noticed any particular circumstances which might cause these?"
    4. "Have you had any chest pain?"
    7. "Have you had any breathing problems?"
    8. "Do you feel any dizziness or light-headedness?"

9. "Have you ever passed out?"
10. "Do you have a fever?"
11. "Do you get tremors in your hands?"
12. "Do you sweat excessively?"
13. "Do you get headaches with these?"
14. "Have you noticed any swelling in your legs?"

Past Medical History:

1. "Do you have any other medical problems?"
2. "Do you have any heart problems? DM? High blood pressure? High cholesterol? Thyroid problems?"
3. "Do you have any anxiety disorder?"

Allergies:

1. "Do you have any allergies?"

Family History:

2. "Any family h/o heart problems? Palpitations? Thyroid problems? Panic or anxiety disorder?"

Social History:

3. "Do you smoke? How much and for how long?"
4. "Do you drink alcohol? How much and for how long?"
5. "Do you drink caffeinated beverages?"
6. "What do you do for a living?"
7. "Do you experience any stress at home or work?"

Medications:

1. "Are you taking any prescription medications? Over-the-counter medications?"
2. "Have you ever used any recreational drugs like cocaine or marijuana?"

Physical Examination:

1. Wash your hands.
2. Perform the proper draping technique.
3. Examine the eyes/hands for pallor.
4. Check the thyroid.

5. Auscultate the heart.
6. Auscultate the lungs.
7. Quickly palpate the abdomen.
8. Check for leg swelling/calf tenderness.
9. Check hands for tremors.
10. Examine without the gown, not through the gown.

Differential Diagnosis:

1. Cardiac arrhythmias
2. Valvular heart disease
3. HOCM (Hypertrophic obstructive cardiomyopathy)
4. Hyperthyroidism
5. Hypoglycemia
6. Pheochromocytoma
7. Fever
8. Anxiety/Panic attacks

Investigations:

1. CBC with differential, ESR
2. 12 lead EKG
3. Serum TSH
4. Blood glucose, serum electrolytes (Na, K, Cl, CO_2, BUN, Cr)
5. Holter monitoring/loop monitor
6. 2D-echo

Pre-emp Checkup

Case of a 25 yo M who came for Pre-employment Check-up

1. You may get these kinds of cases as either "Pre-employment check-up" or as an "Insurance check-up". They will tell you everything you have to do. Some may ask you to fill out a form (It will be provided for you.). If they want you to do any specific examination, do that, but do all the things that are mentioned in the form first.
2. You can fill out the form after you leave the room. If the SP asks about the

form, tell him that you will mail it to his home.

3. After you finish the examination, ask, "Do you have any questions?" Answer any questions, and then take a relevant history.
4. In case you were not provided with a form, you will have to take a simple general history. Ask cardinal symptoms of each system.
    1. "Do you have any cough?" ("No.")
    2. "Do you have any problems with breathing?" ("No.")
    3. "Do you have any chest pain?" ("No.")
    4. "Do you have headaches?" ("No.")
    5. "Do you have a fever?" ("No.")
    6. "Do you have any pain?" ("No.")
    7. "Do you have weakness in the extremities?" ("No.")
    8. "How is your bowel habit?" ("Pretty good.")
    9. "How is your bladder function?" ("Good.")

1. Then you must ask PAM HUGS FOSS.
2. Please do not forget to ask about allergy, smoking, alcohol, and sexual history.
3. Here is the sample of the form that you might get. It may not be exactly like this. You may get some of the components of this form.
4. If they ask you to measure blood pressure (on the form/doorway information), you have to measure it. This is different from all other cases where you don't need to check blood pressure.
5. After finishing the case, you just have to fill out this form. You don't need to write any history, or things that they have not asked you. All you have to do is fill out the form.

Height	
Weight	
Blood pressure	
Pulse rate	

Lung auscultation	
Heart auscultation	
CNS reflexes	
Abdomen	
Spine examination	

Shoulder pain Case

Shoulder pain sample case

Door way information:

Case: 56 year old Scott comes with left sided shoulder pain; vitals were normal.

Simulated encounter

- Once you see the doorway information all you need to do is just note the name of the patient. Take 15-30 seconds to make a mental checklist of differential diagnosis of shoulder pain.
- Knock on the door.
- Make comfortable eye contact - empathic
- Patient will be on the table in an awkward position, in pain.. Don't change the position of the patient. Stand in front of the patient about two or three feet away.. You adapt to his position.
- We advise you to stand instead of sitting.
- Say, "Hello Mr. Xyz. It's nice to meet you. I'm here to ask you some questions and see what I can do to help you." (Speak in a reassuring tone)
- **Don't** shake his hand because he will be supporting his painful hand with the opposite hand. (You will lose points if you cause the

patient unnecessary pain.)

- Patient says, "My shoulder hurts so much, I can't even sleep."
- First, ask an open ended question: "Mr. Scott, can you tell me something about your pain?" His answer will cover some aspects of pain like - location, quality, and some others of LIQOR AAA. Make a mental note and don't ask those aspects again. If you are caught asking again tell him that you were just checking.
- Ask all pain questions (LIQOR AAA) plus the functional impairment questions, i.e. occupational impairment, sleep, and help at home. (Remember all three will be in the check list.)
- The patient will respond to all LIQOR AAA questions. Ask specifically whether he took any medications and did he get any relief with them.
- Always ask the precipitating factor of pain: SP may say that he fell down the stairs at night while going to the kitchen to get a drink of water.
- Then ask about deficits:
- "Do you have tingling (pause) or numbness?" (no)
- "Did you notice any swelling or redness after the fall?" (no)
- "Do you have pain in any other part of your body?" (yes; palm hurts.)
- "Are you able to use your arm?" (No; because painful)
- "Do you feel any weakness?" (No, only pain)

PMH:

Then ask **PAM HUGS FOSS**

- "Now, I need to ask you a few questions about your health in the past. Is that ok with you?" ("Yeah")
- Ask the second open ended question "How has your health been until now?"
- "Have you ever had any problems with your shoulder?" (Yes, I had an injury to my left arm three yrs ago. I had a humerous fracture)
- "Do you have any other medical problems?" ("Yes, I did have acid peptic disease.")
- "Are you allergic to anything?" ("Yes; I am allergic to penicillin..")
- "Have you taken any medications?" ("Yes, only Ibuprofen for

pain.")

- "Do you have any problems with your digestion or your bowels?" ("I have been constipated lately.")
- "Do you have any problems with your urination?" ("No.")
- "Now, I need to ask you a few questions about your family health. Is that ok with you?" ("Yes")
- "Are your parents living?" ("No, they died of old age.")
- "Has anyone in your family had medical problems?" ("Yes, my father and brother had pulmonary fibrosis.")
- "Now, I need to ask you a few personal questions. Please do not feel embarrassed. Everything you say will be kept confidential.".
- "Are you sexually active?" ("No")
- "Now, I need to ask you a few questions about your lifestyle."
- "Do you use tobacco?" ("No")
- "Do you drink any type of alcoholic beverages?" ("Yeah. I have 2 shots of scotch on the rocks every night. Been doing so for the past 10 years.")
- "Do you use any recreational drugs?" ("No")
- Here, ask another open- ended question for social and occupational history. Example: "Tell me something about your life at work and home."("Cannot go to party today because not able to drive.")

Examination:

- After taking history, ask " All right; thank you for being cooperative. Now, I'm going to give you a physical. Before I do, is there anything you would like to ask me? I would be happy to answer any questions" (Remember, he may tell you like this: ' Please be gentle with my arm doctor'). *Bonus point! Console him saying, "I know that you are in pain. I will try to do my exam as gently as I can. Does that sounds good?' (You will see the relief on the patient's face and the importance of an open ended question. This question will help you to ask and counsel the patient more effectively.)
- "Please excuse me for a few seconds while I wash my hands."
- Always start with local examination i.e. painful shoulder
- Expose the joint properly while draping the other parts.
- Before inspection tell the patient what you're looking for, i.e.

redness and swelling. Don't just look. He should know that you are looking. Palpate and compare both joints.

- Palpate for swelling, warmth, and crepitus. Tell him first that you will be very gentle. Say sorry if he complains of tenderness during the examination.
- Most of the times SP will have tenderness on the anterior part of his shoulder joint.
- Check range of motion (ROM) in abduction, adduction, flexion, extension, and internal and external rotation. (Obviously SP will have restricted abduction beyond 60 degrees i.e. he will complain of pain after 60 degrees). Always adduct the patient's arm across the chest (crossover test).
- Check reflexes: pin prick sensations
- Check the opposite arm
- Check hand in detail
- Look at the legs very quickly
- Listen to the heart and lungs for 10 to 15 seconds.

Counseling:

- Explain the probable diagnosis, follow-up after investigations, and the availability of physiotherapy.

Diagnosis

- Shoulder dislocation
- Shoulder fracture
- Rotator cuff tear
- Subacromial bursitis
- Ligament sprain

Work up

- CBC
- X-ray of shoulder joint two views, including elbow
- X-ray hand two views
- MRI of shoulder
- ANA and Rheumatic factors

Note: ***You may get a case very similar to this in the real exam**. The important thing that you need to remember from this case is: "You have to ask all PAM HUGS FOSS for every case no matter what the complaint is because

they will have those in the check list.

Smoking Cessation

Mrs. Jacobson (55 years old)

Basic questions to ask smoking patient:

- "Can you please tell me more about your smoking?"
- "When did you start smoking?" ("When I was in college")
- "As you know, some people smoke and some people don't. What were the circumstances that caused you begin smoking?" ("I was in college and everyone smoked. My father had smoked my entire life.")
- "How do you feel about smoking? I mean do you like smoking?" ("Yes, I love smoking. It's a social time and it relaxes me.")
- "How many cigarettes do you smoke a day?" ("About two packs.")
- "Are you concerned about your health?" (" No, I don't inhale. I just as soon could get run over by a truck tomorrow.)
- "Is stress or depression a reason for your smoking?"("When I'm tense or nervous smoking helps me relax.")
- "Have you ever had any smoking related problems, like any cough or shortness of breath?" ("Well, when I get a cold it goes into my chest and I get very congested. I have a deep cough. Also, I used to play tennis a lot and find it difficult now because I start breathing so hard.")

In your counseling with a smoking patient, don't begin by attacking her negatively. Rather than beginning with, "Mrs. Jacobson, you must stop smoking, you're killing yourself." The patient is being told to stop a habit/addiction that is incredibly difficult to do. There are social, emotional, and physical aspects all involved in this decision. Depending on how you pose your comments and questions, the patient could feel defensive and angry, or comfortable and willing to open up. Always start in a non-judgmental manner.

- You: "Most patients I've counseled have tried to stop smoking at some point. Have you ever tried to quit?" ("Yes, once.") " Why?" ("Because my children told me I should and they didn't want second hand smoke.") "What happened?" ("I gained weight and became very irritable.") How did you deal with it?" (" I decided my father had

smoked his entire life and never had a problem. He made his choices and I should make mine. So I started again and feel better.")

- "Mrs. Jacobson, I understand those reasons, however the benefits of giving up smoking are huge. Do you know that your chance of cancer, heart attack, or lung disease will decrease greatly if you quit smoking? (" Yes---I know.") "Your breathing will improve. You will have more energy." ("I've had to stop playing tennis because I get too hot and tired.") " If cigarettes are being used to manage your stress, would you consider other stress management techniques?" (" Like what?") " Have you ever tried a nicotine patch? ("No, I really don't know anything about them.")"I can give you some material to read. We have all kinds of counselors who have been exactly where you are. There are many options they can offer you. There are really fun exercise and recreation programs offered for you individually or with a group." ("I enjoy swimming if the water is warm.") "That would be perfect exercise. It is one of the best ways to get your heart pumping and every part of your body moving." ("I might be interested in talking with someone about that.")
- "Tell me what kind of support system you have if you decided to try and stop smoking? (I don't have any one)
- "Would you like for me to have someone contact you or I could give you a number to call? ("Yes, I guess I'd like that. Maybe I'll ask another friend who also smokes to try this with me.") "That sounds fine. Find rewards to honor and reinforce your healthy new behaviors."("How about going out to dinner with the money we save on the cigarettes we don't smoke!")"Sounds great. Let's get back together and discuss how you're doing?" ("Ok.")
- If the patient does not want to quit smoking you can say: "It seems you really don't want to give up smoking right now. I wonder if you could cut back from two packs to one pack a day?"
- Always praise the patient using positive expressions i.e. 'Excellent" or 'That's great'. Finally, repeat sentences like, "I appreciate the motivation that you have to quit smoking"

Dealing with dramatic style

- You might get a patient who may charm you, fascinate you, and

even frustrate you. They may exaggerate the symptoms. Always listen and observe as the patient talks. Remain calm, gentle, and firm.

- A patient may compliment you on your hairstyle or your dress. He may ask about your personal life or social relationships. You can say, "Well, we are really here to talk about your opinion and your problems. I am interested in hearing more about you. How do you handle this or how did you manage that, etc.?"
- Sometimes the SP may prevent you from obtaining a good history. A good history is really important to find out the cause. It's like obtaining H/O use of recreational drugs. In those cases you can say, "I've noticed that whenever I try to ask about sexually transmitted diseases you tend to change the topic. That really concerns me. Can you please answer my questions?" (Don't say, "Why don't you answer my question?")

What should you say if you suspect a STD in a patient with vaginal discharge? The patient insists that her boyfriend has been faithful and it was impossible that he would have had sex with anyone else?

- You need to remind the patient before counseling that you haven't made any diagnosis yet. (Usually you don't in most CSA cases.) So, always say that you have to run a few tests before confirming the diagnosis and there is no way you can confirm or deny STD in this CSA case because you haven't done a pelvic exam. If you still want to offer some counseling you can say, " I appreciate the trust you have in your boyfriend's faithfullness but unfortunately, we see these kinds of problems in our clinic often. So, even though it's highly unlikely, according to your history, there is always a possibility of STD. Let me run few tests and once we get the results we can get back together again and discuss my diagnosis and suggested treatment plan, if needed. Is this ok with you?"

Case Of Spells/Loss Of Consciousness

Syncope is defined as a sudden and transient loss of consciousness. Syncope

has very broad differential diagnosis. Most of the time the underlying cause of syncope can be diagnosed with good history, physical examination and some basic labs.

The common causes of syncope include:

- Cardiac causes - Arrhythmias, CAD and acute coronary syndromes, aortic stenosis, HOCM
- Vasovagal syncope
- Neurological causes - TIA, stroke, seizures, migraine
- Medications or toxins
- Unexplained syncope
- Psychiatric cause - Personality disorders, hyperventilation and conversion disorder

Scenario:

Basically, ask these questions:

- Ask him/her to explain the whole episode of spell (Can you please explain me more about your spell?) - Open ended question.
- If he doesn't cover what he was doing at the time of spell and how much time he lost his consciousness in his history, you need to take that history.
- "Do you have any idea of what might be the cause of your spell?"
- "Is this the first of these spells? Have you had similar spells before?"
- "Was there anyone around when this occurred? What did they say about your spell?"
- "Are you back to normal now? Were you feeling fine before the event and between the spells?"
- "Did you have any nausea or vomiting before the spell?"
- "Have you had any chest pain?"
- "Have you had any breathing problems?"
- "Have you ever had any palpitations?"
- "Have you noticed any weakness in your legs and arms?"
- "Have you noticed any tingling and numbness anywhere?"
- "Has anyone told you that you had jerky type of rhythmic movements?"
- Ask about any sudden visual changes or blurriness.

- Ask about any history of head trauma.
- Ask about bowel and bladder incontinence.
- Ask about the risk factors for stroke, diabetes, hypertension or heart problems etc.
- Ask about all of his medications including over the counter and illicit drugs.
- Ask if there was any history of seizures in the past.
- Ask about any history of anxiety or past psychiatric disorders.

These are the basic questions that you have to ask for any patient having spells (syncope). Don't forget to ask all the general information like family history, allergic history, and social history (smoking, alcohol), as for every other patient.

Examination:

- Order orthostatic changes (both BP and HR) in the investigations section.
- Do complete neurological exam
- Auscultate heart
- Check for carotid bruit
- Check for peripheral edema

Investigations:

- EKG/ECG
- 24 hr Holter monitoring
- Exercise testing: Order in patients with a history of exertional syncope.
- 2D-Echo
- Upright tilt table test: For neurocardiogenic syncope
- Neurological investigations: CT, MRI, EEG and carotid doppler
- If you are suspecting drug abuse, order a Toxic screen.
- Blood sugar and metabolic screen - order if you are suspecting a hypoglycemia or electrolyte imbalance.
- FOBT or stool guaiac- If you suspect GI bleeding, which can result in hypovolemia, and syncope.

Case of a 69 yo M with Terminal Cancer Requesting Pain Medication

1. If you get a case like this, you really have to show empathy and care. Start with a formal greeting, and place a hand on the patient's shoulder. Make eye contact, and then ask an open-ended question.

History Taking:

1. "Mr. XYZ, please tell me. How can I help you today?" ("I am having pain in my stomach.")
2. "I have been informed that you have been diagnosed with cancer. Is that correct?" ("Yes.")
3. "Could you please tell me more about your cancer?" ("I have pancreatic cancer. It was diagnosed 3 months ago")
4. "I am very sorry to hear that." ("Thank you, doc.")
5. "I know it's very difficult. I can understand what you are going through. I want you to know that I am here to help you if you need anything to make you feel comfortable." ("Thank you very much.")
6. "Can you please explain to me a little bit more about your pain?" ("It's a stabbing type of pain.")
7. "How severe is the pain, on a scale of 1 to 10?" ("It's a 10.")
8. "Do you think there is anything that makes your pain less?" ("Pain medication, sometimes.")
9. "What makes your pain worse?" ("I think it's already at its worst.")
10. "Do you have pain anywhere else?" ("Sometimes my back hurts.")
11. "Are you using any medication for your pain, especially any narcotics or morphine?" ("Not much.")
12. "Do you have any other complaints, other than pain?" ("I am feeling tired most of the time.")
13. "How is your appetite?" ("I don't have much of an appetite.")
14. "Have you lost any weight?" ("Yes, around 12 pounds in three months.")
15. "Do you have a fever?" ("No.")
16. "How are your bowel movements?" ("Fine.")
17. "Do you have any problem urinating?" ("No.")

18. "How is your mood?" ("Not good doc, I feel depressed.")
19. "Have you had any thoughts of ending your life?" ("Not really, so far.")
20. "Can you please tell me about your home situation?" ("I don't have anyone, doc. I live alone.")
21. "Do you have anyone to help or support you, like any friends or family members?" ("I have a few close friends. Yes, they'll certainly help if needed.")

Physical Examination:

1. Wash your hands.
2. Perform the proper draping technique.
3. Auscultate and palpate the abdomen.
4. Quickly auscultate the heart and lungs.
5. Examine the conjunctiva to check for pallor or jaundice.
6. Examine without the gown, not through the gown.

Counseling:

2. There is no single, correct way to give counseling. This is an example for you to give counseling but bear in mind, it is not necessary that you follow this exactly, word for word. This just gives you an idea to help you build your own way, in which YOU ARE COMFORTABLE. It will be fine as long as you show that you are sensitive, supportive, and conveying necessary information.
    1. "Mr. Xyz, I will certainly help you in relieving your pain. I will prescribe a narcotic, like morphine. I would also like you to be aware of certain things that will be necessary at some point in your life. I am very sorry to ask you these questions, but I hope you understand the situation." ("Thank you, doc. Don't worry. Ask me.")
    2. "Where do you want to live? Do you want to stay at your home or at a nursing home?" ("I want to stay at home.")
    3. "Do you know about 'hospice'?" ("Not much.") "Okay, let me explain about hospice. Hospice care is a choice you can make to enhance your quality of life in a terminal stage. You can choose to die at home with the support of family, friends, and caring professionals. Over 90% of hospice care is provided at your home. The advantage of hospice care is

that the providers have the skills and resources to permit you to live as pain-free, as comfortable, and as full a life as possible. In addition to providing pain relief, hospice care emphasizes comfort measures and counseling to provide social, spiritual, and physical support to you and your family. All hospice care is under professional medical supervision. So, I strongly advise you to take hospice care." ("Thank you very much, Doc. You relieved most of my concerns.")

4. "Are you aware of advance directives?" ("No, not much doc.") "An 'advance directive' or a 'living will' will enable you to give your opinion on how you should be treated when you reach the terminal stage of the disease, or when you aren't in an ideal state of mind to make a decision anymore. You can give the right to a loved one to make that decision for you. Do you understand what I am saying?" ("Yes, doc.")
5. "Do you have any other questions?" ("No, not much, doc.")

Differential Diagnosis / Investigations:

3. You don't need to write a differential diagnosis or investigations if the problem is purely terminal cancer.

Telephone Consultation

History:

Good morning, Mrs. Smith. This is Dr. XYZ. Tell me. What can I do for you today?

(“Doc, my son has been vomiting. I was wondering if you could give me some advice on what I should do about it.”)

Okay, Mrs. Smith. I’d like to get a few details from you about your son.

How old is he? (“He’s 5 years old.”)

How long has he been vomiting? (“Since yesterday.”)

How many times has he vomited since yesterday? (“Around 2-3 times.”)

Has he been vomiting large amounts? (“Yes, I would say so.”)

What does the vomitus contain? (“Mostly, it’s the food he eats.”)

Did you notice any blood in the vomitus? (“Not at all.”)

Is the vomitus forceful? (“No, it isn’t.”)

Is it preceded by nausea? (“Yes, I think so.”)

Does he have any pain in his belly? (“Yes, he did mention that his belly hurts a bit.”)

Are there any changes in his bowel movements? Any diarrhea or constipation? (“No”)

Does he have a fever? (“Actually I did take his temperature and it was normal.”)

How is his appetite? (“He hasn’t been eating too well. He fears he would vomit.”)

Did he ever have similar episodes in the past? (“No”)

Did he eat out recently, like in a party or restaurant? (“No, he didn’t.”)

Does he have any headaches? (“He didn’t mention that to me.”)

Is he usually a healthy child or does he frequently get sick? (“Actually, he rarely gets sick. I would say he’s pretty healthy.”)

Was he ever diagnosed with any medical illness before? (“No”)

Has he received all the vaccinations appropriate for his age? (“Yes he definitely has.”)

Is he currently taking any medications? (“No.”)

Is there another pediatrician who takes care of him on a regular basis? (“Yes,

he had a pediatrician in _____ before. We just recently moved here.")

Well, Mrs. Smith, based on the information that you just provided, I think your son may be experiencing stomach irritation. We have to determine what is causing it. I would like to personally examine him and perform some basic labs before I make a diagnosis or give any advice, especially since he is a new patient. Will it be convenient for you to bring him here to the hospital? ("I'm sorry. It's not possible for me to bring him in. Can't you just give recommendations over the telephone?")

Is there a reason why it isn't possible for you? ("Actually, my husband is out of town and I have no means of transportation.")

In that case, I suggest that you call either a cab or 911, and arrange for your child to be brought here to the hospital. That way, you won't have to worry about transportation and your child can be examined as well. Does that sound good to you? ("Absolutely.")
Mrs. Smith, I hope you understand that all this is for the best interest of your child. I do not want to jeopardize his health at any cost. ("Yes, doc, of course, I understand and appreciate your concern.")

Alright then, I will see you once you get to the hospital. Take care, Mrs. Smith.

*Note: It is important to convince the mother to bring her child to the hospital. Personal assessment of the child is necessary to determine hydration status and the need for medical/surgical intervention.

Case of a 20 yo F Complaining of Vaginal Bleeding

Vital Signs:

1. BP 110/70 mm Hg
2. Pulse 80/min

3. RR 16/min
4. T 36.7C(98°F)

History Taking:

1. Please remember that you need to use appropriate transition sentences. Below are suggested questions to ask:
    1. When did the bleeding start?
    2. Was the onset gradual or sudden?
    3. Can you describe the bleeding?
        1. For example, is it bright red or clotted blood?
        2. Is the blood pure or does it contain tissue like substance? (A molar pregnancy would have grape like tissue.)
    4. Has it been a continuous flow or spotting?
    5. What were you doing when it started? Were you sleeping or having sex?
    6. Do you have any other symptoms besides bleeding? Did you have abdominal pain? Fever? Vomiting?
    7. Were you ever involved in any accident/trauma?
    8. Have you ever been pregnant?
    9. When was your last menstrual period (LMP)?
    10. Can you describe more about your menstrual cycle?
        1. How heavy is the flow?
        2. How many pads do you use per day?
        3. How long are your periods?
        4. Are your periods regular or irregular?
    11. Have you had any abortions?
    12. Have you ever been tested for STDs?

Past Medical History:

1. Have you ever had any history of bleeding? Were you ever hospitalized for bleeding?

Medications:

2. Are you currently taking any medications?
3. What medications have you recently taken?

Family history:

1. Do you have a family history of bleeding disorders?
2. Does anyone in your family have a history of multiple abortions?

Sexual History:

1. Are you married?
2. If **yes:**
    1. Do you have any other sexual partners? (yes)
    2. Do you use any means of contraception?
1. If **no:**
    1. Do you have any other sexual partners? (yes)
    2. Do you use any means of contraception?
1. When was your last sexual contact?

Social History:

1. Do you smoke?
2. Do you drink alcohol?
3. Do you use illicit drugs? (Cocaine may cause bleeding.)

Physical Examination:

1. Wash your hands.
2. Perform the proper draping technique.
3. Look for other sites of bleeding, i.e. nose or gums
4. Check for orthostatic hypotension.
5. Auscultate the abdomen.
6. Percuss the abdomen for liver span.
7. Palpate the abdomen superficially.
8. Palpate the abdomen deeply.
9. Check for rebound tenderness.
10. Ask to perform a pelvic exam.
11. Examine without the gown, not through the gown.

Differential Diagnosis:

1. Regular menses
2. Abortion

3. Pregnancy
4. Ectopic pregnancy
5. Hydatiform mole

Investigations:

1. Pelvic examination
2. Pregnancy test
3. CBC with differential
4. Transvaginal ultrasound
5. Serum ß-HCG levels
6. Serum TSH

A 25-year-old female with nausea and vomiting

First, think about the common causes of nausea and vomiting in this age group.

Gastroenteritis (food poisoning): Ask about having food outside, i.e., travel history. Are any other members being ill with associated symptoms, like abdominal cramps and diarrhea?

Obstructing disorders: Pyloric obstruction (classically, vomiting within one hour after having food); Intestinal obstruction (vomiting late post prandial period); Constipation (Is she passing gas? Do not ask about 'flatus'. If you do, SP will say, "What is that?'*. Relief of the pain with emesis is very characteristic of small bowel obstruction. Vomiting has no effect on acute pancreatitis or cholecystitis.

Inflammatory diseases: Pelvic inflammatory disease (PID), Cholecystitis (pain in the right hypochondriac region); Acute pancreatitis (severe epigastric pain radiating to back); Appendicitis (initially, periumbilical pain, later to right lower quadrant pain); Acute pyelonephritis.

Impaired motor function: Diabetic gastroparesis, DKA, GERD - (Ask about any history of diabetes. This female may be, type 1).

Intracranial pathology: Malignancy and infections - Ask about fever, headaches, and the quality of vomiting (projectile or not).

Drugs: Digoxin, cancer chemotherapy - Ask if she is taking any medications.

The two most common conditions, (you will most likely be tested on in the step-2 CS) are pregnancy and anorexia nervosa. You should not forget to ask about the LMP, because if you get a case of nausea and vomiting in the step-2 CS, it is most likely a pregnancy. In fact, the SP may ask, "Doc, am I pregnant?"

HPI:

- When did the vomitings start?
- Was it a projectile (forceful) vomiting?
- What does the vomitus look like? What color was it? Was there any blood? How many times have you had so far?
- Do you have any abdominal pain or back pain?
- Do you have any diarrhea?
- Do you have constipation?
- Do you have fever and chills?
- Have you had any headaches?

- Do you have any burning urination?
- When was your last menstrual period?
- Is there a chance you could be pregnant?
- Have you had any vaginal discharge/bleeding?
- Did you eat food outside? Did you eat anything like unpasteurized or undercooked food, unusual foods, dairy products, and seafood?
- Did any of the other family members get sick?

PMH:

1. Have you ever had similar episodes in the past?
2. Do you have any other past medical problems? (Diabetes)
3. Have you ever been admitted in the hospital?
4. Have you had any abdominal surgeries?

SH:

1. What do you do for living?
2. Do you smoke?
3. Do you drink alcohol?
4. Do you use IV drugs?
5. Do you have multiple sexual partners? What kind of contraception do you use?

All:

1. Are you allergic to any medications?

Meds:

1. What medications do you use on regular basis? Did you take any over-the-counter medications, such as ibuprofen?

Examination:

- Examine oropharynx
- Auscultation of the abdomen (decreased bowel sounds indicates ileus; increased bowel sounds indicates bowel obstruction)
- Abdominal palpation, both superficial and deep
- Check for CVA tenderness, if needed
- Fundoscopy if you are suspecting intracranial causes
- Explain about the need of rectal examination and pelvic examination (pregnancy)

- Quick lungs and heart exam

Investigations:

- CBC with differential
- Serum electrolytes (Na, K, Co2, Cl, BUN, Cr)
- Pregnancy test (must, for this female)
- Urinalysis and culture and sensitivity, as needed
- Abdominal x-ray, once the pregnancy test is negative
- Serum amylase and lipase (if you are suspecting), as needed for acute pancreatitis
- Liver function panel, as needed
- Ultrasonogram (acute cholecystitis)
- Blood sugar for diabetes mellitus
- Stool studies, as needed (fecal leukocytes, stool ova and parasites, stool culture, C. difficle)
- EKG should be obtained if patient has risk factors for MI (sometimes inferior wall MI is apparent with vomiting, especially in diabetics)

PRACTICE CASES

case1 Scenario

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30 Yr. O/F Complaining of Abdominal Pain

Vitals

- Pulse--98/min
- B.P--120/75 mm of Hg
- Temp-101.3
- R.rate--22/min

Make a mental checklist of Differential Diagnosis

- Pelvic inflammatory disease
- Pelvic abscess
- Endometriosis
- Urinary tract infection
- Appendicitis
- Rupture/torsion of ovarian cyst

- Acute cholecystitis
- Renal colic
- Ectopic pregnancy
- Abortion
- Acute gastroenteritis
- Inflammatory bowel disease

case1 SP

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mrs. Mary, age: 30yrs
- Have abdominal pain since 12 hrs
- Started slowly, progressively increasing
- 7-8/10 in severity
- Right below the umbilicus
- It's a type of sharp pain
- All over your lower abdomen
- Began after eating a large meal
- Moving around makes it worse
- No alleviating factors
- Not associated with vomiting but have nauseating feeling
- Passing urine more number of times and have burning urination
- No bowel problems
- Last menstrual period was 3 weeks ago
- No discharge from vagina/no bleeding from vagina
- Have fever since yesterday associated with chills and rigors
- Have one episode of urinary tract infections (UTI) in the past
- No allergies
- Once hospitalized for evaluation of UTI
- Have multiple sexual partners
- Using oral contraceptive pills
- Families' health is normal

- Smoking – No
- Alcohol- No
- Recreational drugs- No
- Occupation: Working as a receptionist
- Appetite and wt is normal
- No illicit drug intake

Ask this qt - Doc is it an appendicitis?

case1 Pt Notes

C.C: A 30 Y/O WF with abdominal pain.

HPI: A 30 Y/O WF who has a H/O UTI, pyelonephrtis who is in her usual state of health until yesterday started to have abdominal pain right below the umbilicus. The pain started after having a heavy meal; She describes the pain as sharp, 6-7/10 in severity, gradual in onset and progressively increasing. Later on, the pain moved to the lower abdomen. Moving around makes the pain worse; denies any alleviating factors. The pain is associated with nausea and 2 episodes of non-bloody vomitings. She is also C/O having frequent burning urination, which started at more or less same time. She also has fever associated with chills and rigors.

ROS:	She has regular bowel movements; no diarrhea/constipation. She denies resent change in appetite and weight. Rest is unremarkable.
PMH:	UTI one episode. Hospitalized once for evaluation of possible pyelonephritis.
All:	NKA
SH:	Working as a receptionist. She never smoked nor had alcohol.
SxH:	Multiple sexual partners, her partner doesn't use condoms, uses oral contraceptive pills. Never been tested for STDs.
FH:	Both parents are alive and healthy
Ob & Gyn:	LMP 3 weeks ago. No priors STD's. No H/o vaginal discharge

PE:

Vitals:	Pulse 98/min, B.P -120/75 mm of Hg, R.R - 22/min, Temp 101.3^0F
Gen:	AAOx3 (Alert, Awake and oriented to time place and person), in mild to moderate pain.
Heart:	S_1, S_2 heard. No thrills/murmurs /gallops/rubs.
Lungs:	CTA B/L (Clear to auscultation bilateral)
Abdomen:	Flat, no scars and pigmentations. BS are + in all 4 quadrants. Tenderness is present in periumbilical, RLQ and LLQ regions. Not distended. No rebound/guarding/organomegaly. CVA tenderness is negative. Psoas and obturator signs are -

D/D:
Pelvic Inflammatory disease
Pelvic abscess
Urinary tract Infection
Appendicitis
Rupture or Torsion of ovarian cyst

Investigations:
Rectal and pelvic examination
CBC with differential
Urinalysis including C/S
Pregnancy test
Ultrasound Abdomen

case1 checklist

History Taking (General Proforma)

1. Asked about the location of pain
2. Asked about the intensity of pain
3. Asked about the quality of pain
4. Asked about the origin and duration of pain
5. Asked about the progression of pain
6. Asked about any radiation of pain
7. Asked about the aggravating factors.
8. Asked about the relieving factors
9. Asked about any vomiting
10. Asked about fever
11. Asked about urinary problems
12. Asked about bowel problems.
13. Asked about last menstrual period
14. Asked about vaginal discharge
15. Asked about vaginal bleeding

Past History

1. Asked about similar episodes in the past
2. Asked about history of allergies
3. Asked about past medical problems (high blood pressure, diabetes, kidney problems, urinary tract infections)
4. Asked about previous hospitalizations (surgery)
5. Asked about family health.
6. Asked about appetite and changes in weight

7. Asked about smoking
8. Asked about alcohol
9. Asked about Obg/gyn history (in detail)
10. Asked about sexual history (in detail including contraception)
11. Asked about medications
12. Asked about occupation

Examination

1. Examinee washed hands
2. Auscultated abdomen
3. Palpated abdomen superficially
4. Palpated abdomen deeply
5. Checked rebound tenderness
6. Looked for CVA tenderness
7. Performed Psoas sign and obturator sign
8. Examined without gown not through the gown

Counseling

1. Explained the physical findings and diagnosis
2. Explained further work up (Blood tests, urinalysis, ultrasound, abdomen x ray)
3. Explained the importance of safe sexual practices and use of condoms.
4. Asked to perform rectal and vaginal examination

Communication Skills

1. Knocked before entering the room
2. Introduced himself and greeted warmly
3. Used my name to address me
4. Paid attention to what I said and maintained good eye contact
5. Asked few open ended questions
6. Asked non leading questions
7. Asked one question at a time
8. Listened to what ever I said with out interrupting me in between

9. Used lay man's language
10. Used appropriate transition sentences
11. Used appropriate draping techniques
12. Summarized the history and explained physical findings
13. Expressed empathy, made appropriate reassurances
14. Asked whether I have any concerns/ questions.

D.D for this Case

1. Pelvic inflammatory disease
2. Pelvic abscess
3. Urinary tract infection
4. Appendicitis
5. Rupture/torsion of ovarian cyst

Investigations

1. Rectal and vaginal examination
2. CBC with differential count
3. Urinalysis
4. Pregnancy test
5. Abdomen x ray
6. Ultrasound abdomen

27 Yr. O/F complaining of rash

Vitals

- Pulse--78/min
- B.P--120/75 mm of Hg
- Temp-98.3 F
- R.rate--22/min

Make a mental checklist of Differential Diagnosis

- Infections
- Insect borne diseases
- SLE
- Photo dermatitis
- Drug induced
- Occupational exposure
- Rheumatoid arthritis
- Other autoimmune diseases

case2 SP

If doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are a 27y/o female c/o rash since 7 days on face and neck.
- It is a flat rash appeared after gardening for 3 hrs.
- Remained same as a flat rash but is increasing in size day by day
- Increases on exposure to sun
- No relieving factors
- No new areas were involved
- No itching/burning
- No redness of eyes
- No tenderness/no numbness
- You also have joint pains since 4 days, early morning stiffness
- Have fever Since 2 days
- No breathing problems/no chest pain
- None of the family members or close contacts has similar problems

- No h/o travel
- No history of similar past episodes
- Allergic to penicillin
- Past h/o joint stiffness several times, subsides on its own
- Never hospitalized
- No urinary and G.I problems
- Family—mother has rheumatism
- Obg/gyn—Has never been pregnant, last menstrual period was 2 weeks ago.
- Sexually active with boyfriend, using condoms regularly
- No smoking, no alcohol
- No recreational drugs. Took aspirin for headache 7 days ago
- Occupation—works in chemical manufacturing company

case2 checklist

History Taking (General Proforma)

- Asked about the location of rash
- Asked about whether the rash was initially flat or raised/blistered
- Asked whether the rash changed to any character
- Asked about any new areas involved
- Asked about the progression of the rash
- Asked about the aggravating factors.
- Asked about the relieving factors
- Asked about any precipitating factors
- Asked about itching and burning over the rash
- Asked about any pain or numbness over the rash
- Asked about any breathing problems/chest pain
- Asked about redness of eyes
- Asked about any joint pains.
- Asked about fever
- Asked about any one else in close contact have similar rash
- Asked about recent travel

- Asked about any animal contact
- Asked about history of insect bites and H/O outdoor activities in the recent past

Past History

- Asked about similar episodes in the past
- Asked about history of allergies
- Asked about past medical problems (high blood pressure, diabetes, joint problems)
- Asked about previous hospitalizations
- Asked about urinary and bowel problems
- Asked about family health
- Asked about smoking
- Asked about alcohol
- Asked about sexual history
- Asked about Obg/gyn
- Asked about occupation and stresses in life
- Asked about illicit drug intake and other drugs

Examination

- Examinee washed hands
- Looked inside mouth for oral ulcers
- Examined 3 joints
- Listened my heart
- Auscultated all over the lungs
- Examined without gown not through the gown
- Examined face and neck for rash

Counseling

- Explained the physical findings and diagnosis
- Explained further work up (Blood tests)

Communication Skills

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact.
- Asked few open ended questions
- Asked non leading questions
- Asked one question at a time
- Listened to what ever I said with out interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances
- Asked whether I have any concerns/ questions.

D.D for this Case

- SLE
- Rheumatoid arthritis
- Photo dermatitis
- Drug induced
- Occupational exposure
- Infection

Investigations

- CBC with differential count, ESR
- Anti nuclear antibodies assay/Anti ds DNA
- Rheumatic factor assay
- Biopsy of the rash
- Skin tests for allergen

case2 Pt Notes 

CC: 27 y/o WF with rash

HPI:

This is a 27 y/o nulliparous WF noticed a rash over her face and neck after 3 hours of gardening, 1 wk back. There has been no significant change in the rash in terms of morphology; however, the rash has progressed. Rash is limited to face and neck with no itching, numbness, burning sensation, or tenderness. The rash gets worse with the sun exposure. There are no specific relieving factors. No H/o eye congestion. she also noticed joint pains for 4 days with early morning stiffness, and H/o fever for 2 days. No h/o recent travel, or pet exposure. **ROS:** Denies SOB, cough, chest tightness, or diarrhea. **PMH:** Never had rash before. Has a H/O of joint stiffness for couple of times. **All:** PCN. **Med:** ASA for headaches. No other OTC medications. **FH:** M - Rheumatoid arthritis. **SH:** works in chemical manufacturing company. No H/O smoking, ETOH, and IVDA. **SxH:** Single sexual partner. Uses condoms regularly. LMP 3 weeks ago. No H/O STD's, or vaginal discharge.

PE:
Vitals: P.R: 78/min; B.P: 120/75mm Hg; R.R 22/min; Temp: 98.3 F.
HEENT: Face & neck has multiple circumscribed erythematous lesions. No pigmentation, scaliness, vesicles, or cysts are noted. No mouth ulcers. No pallor or jaundice noted. PERRLA. EOMI. ENT were WNL. Musculoskeletal: Joints have normal range of movements. No tenderness, swelling, effusion, or redness. No muscle atrophy. Chest: CTA B/L. Normal S1, S2. No murmurs, gallops, or rubs.

D/D:
SLE
Rheumatoid Arthritis
Photodermatitis
Drug Induced
Occupational exposure

Investigation:
CBC with differential, ESR
ANA, and Anti ds DNA
Rheumatoid factor assay
Skin biopsy
Skin tests for allergen

65-year-old female complaining of arm and leg weakness

Vitals

1. PR: 78/min
2. BP: 160/90 mmHg
3. Temp: 98.3 F (36.7 C)
4. RR: 16/min

Make a mental checklist of Differential Diagnosis:

1. Stroke
2. Transient Ischemic Attack (TIA)
3. Hypoglycemia
4. Subarachnoid hemorrhage
5. Subdural hematoma
6. Intracranial mass
7. Guillain Barré syndrome
8. Complex migraine
9. Conversion disorder

If the doctor asks you anything other than these, just say 'no,' (or) say things that are normal in daily routine life.

1. You are a 65-year-old woman.
2. You have noticed weakness of the right arm and leg.
3. It started an hour ago.
4. You have noticed a gradual increase in the symptoms over the past one hour.
5. The entire arm and leg feel numb.
6. You do not have problem with speaking; No slurry speech.
7. Also noticed mild-to-moderate headache; 5-6/10 in severity.
8. Felt nauseated but no vomiting.
9. No loss of consciousness.
10. No fever; No visual changes, such as blurriness or double vision; No problems with swallowing. No chest pain or palpitations.
11. No bowel problems; No urinary problems; No fits/jerky movements/seizures; No fever.
12. You never had a stroke before; You do not have a history of migraine headaches; You never had any spells or weakness like this before.
13. You have been diagnosed with high blood pressure 25 years ago, and you take atenolol 50 mg once daily.
14. You have had a heart attack (MI) 6 years ago after which you have undergone a bypass surgery. You take baby aspirin (81 mg) for the heart. You also have high cholesterol and you take Zocor (simvastatin) 20 mg daily at bedtime.
15. You quit smoking when you had the heart attack 6 years ago. Previously, you smoked 2 packs of cigarettes per day for a period of 35 years. You drink alcohol only occasionally, like once in a month.
16. You are a widow. Your husband died 8 years ago. You live alone. You have the neighbor, Steve, who is like a son to you. He brought you to the hospital.
17. You had a mother and father who both had high blood pressure and both

died because of a heart attack. There is no family history of brain aneurysms/strokes.

18. You have no known allergies.

Ask this question, if he does not address about the stroke: "Doctor, is it a stroke?"

case3 checklist

History taking including ROS:

1. Asked about the onset of weakness
2. Asked if the weakness was progressive
3. Asked how you felt most of the days before the weakness
4. Asked about the sensory changes
5. Asked about any numbness on one side of face
6. Asked about history of speech problems; history of difficulty swallowing
7. Asked about history of loss of consciousness
8. Asked about any jerky movements/seizure activity
9. Asked about the associated factors, like visual changes such as blurriness/double vision
10. Asked about any palpitations and chest pain
11. Asked about nausea/vomiting
12. Asked about history of fever

13. Asked about any incontinence/bowel or bladder dysfunction
14. Asked about a history of frequent falls/spells
15. Asked about any history of recent head trauma
16. Asked about the home situation

Past Medical History:

1. Asked about similar symptoms in the past
2. Asked about past/other medical problems (hypertension, diabetes mellitus, hypercholesterolemia, myocardial infarction, strokes, and migraine headaches)
3. Enquired about previous hospitalizations (surgery)

Allergies:

1. Asked about any allergies

FH:

1. Asked about any family history of strokes, heart attacks, or aneurysms

SH:

1. Asked about smoking
2. Asked about alcohol intake
3. Asked about living situation

Medications:

1. Asked about my medications

Examination:

1. Checked cranial nerves II to XII
2. Tested muscle power bilaterally and laterally
3. Checked deep tendon reflexes in both upper/lower extremities
4. Checked for sensory modalities proximally and distally and bilaterally
5. Checked cerebellar function tests
6. Checked coordination and gait
7. Did the Romberg's test
8. Listened for carotid bruit
9. Checked for neck stiffness
10. Auscultated heart

Counseling:

1. Told me the probable diagnosis
2. Told me the probable tests that I needed to undergo
3. Advised to admit into the hospital for further evaluation

Communication Skills:

1. Knocked before entering the door
2. Greeted me warmly
3. Made eye contact
4. Introduced himself by name
5. Addressed me by my name
6. Was sympathetic and empathetic towards me
7. Used open-ended questions
8. Used closed-ended questions in a nonjudgmental way
9. Had an understanding attitude towards my anxiety
10. Did not give false reassurances to my questions

D.D for this Case:

1. Evolving stroke
2. Transient Ischemic Attack
3. Subarachnoid Hemorrhage

Work Up:

1. Periodic monitoring of vitals/neuro check
2. CBC with differentials
3. Basic metabolic panel (Na, K, Cl, Co2, BUN, and Cr.)
4. CT scan of the head without contrast
5. Doppler of the carotids
6. ECG and TEE (Trans Esophageal Echocardiogram)

case3 Pt Notes

CC: A 65-year-old white female with weakness of the right arm and leg.

HPI: A 65-year-old white female is brought to the hospital when she started to have weakness in her right leg and arm, for the past hour. She felt tingling and numbness, along with the weakness. The symptoms started, more or less, suddenly and progressed gradually over the last hour. She felt nauseated but no vomiting. She also has a 5/10 headache. She denies any numbness on her face, disarthria, dysphagia, syncope, seizures, visual changes, palpitations, chest pain, or bowel/bladder incontinence. Denies any fever. There is no history of falls or head trauma. **PMH:** No similar episodes, strokes. Has history of hypertension for the past 25 years, hypercholesterolemia, myocardial infarction, and S/P coronary artery bypass graft. **All:** None. **FH:** Father and Mother died with myocardial infarction. No family history of strokes or aneurysms. **SH:** Quit smoking 6 years ago. Smoked 1 pack a day for the past 35 years. Occasionally drinks alcohol. Widow, lives alone at home. **Meds:** Atenolol, ASA, and Zocor.

PE:
Vitals: PR: 78/min, regular; BP: 120/75 mmHg; RR: 22/min; Temp: 98.3F (36.8 C)
CNS: Awake, alert and oriented to person, place, and time. CN: II to XII intact. Motor: Tone - within normal limits bilaterally/laterally; Power is 5/5 - LUE (Left Upper Extremity); 5/5 - left lower extremity; 3/5 on the right upper extremity; 3/5 - right lower extremity. Deep tendon reflexes: 2/4 on right side. 3/4 on left side. Babinski positive on right side. Plantar flexion on left side. Sensations: Pain, temperature, vibration, and sharp and dull sensory perceptions are intact. Romberg's and gait unable to perform, because of severe weakness and unable to stand. No neck stiffness noted. Heart: S1, S2 normal; No murmurs, gallops, or rubs. No carotid bruit.

D/D:
Evolving stroke
Transient ischemic attacks orreversible ischemic neurological deficit
Subarachnoid hemorrhage

Investigation:
CBC with differential
Basic metabolic panel (Na, K, Co2, Cl, BUN, Cr, Ca, glucose)
12 lead ECG
CT head without contrast
Carotid Doppler
Transesophageal echocardiogram

case4 Scenario

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29 Yr. O/F known sickle cell anemia pt c/o chest pain

Vitals

- P.R: 98/min
- B.P: 120/75 mm of Hg
- Temp: 101.3F
- R.R: 22/min

Make a mental checklist of Differential Diagnosis

- Chest syndrome due to sickle cell anemia
- Pneumonia
- Costochondritis
- Pericarditis
- Pulmonary thromboembolism
- Salmonella Osteomyelitis

- Panic attacks

case4 SP

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mrs. Mary, age: 29yrs
- Have chest pain since 12 hrs, started slowly, progressively increasing, 7-8/10 in severity. Located in midline of the chest. It's a type of sharp pain. No radiation.
- Moving around makes it worse, respiration worsens; OTC (Over-the-counter Tylenol) pain killers reduce the pain.
- Have mild shortness of breath.
- Not associated with nausea or vomiting.
- No urine problems. No bowel problems.
- Last menstrual period was 2 weeks ago
- Have fever since 3 days associated with chills and rigors, have cough associated with sputum which is green in color
- No pain in the legs
- H/O pain in fingers in past, h/o pain in abdomen in past
- No allergies
- Once hospitalized for pain in abdomen and diagnosed as sickle cell anemia
- Has one sexual partner
- Using oral contraceptive pills
- Families' health mother suffered from Sickle cell disease. No family history of heart problems, or blood clots
- Smoking – no
- Alcohol- no
- Occupation: Working as a teacher
- Appetite is reduced and wt is normal
- No illicit drug intake
- No blood transfusion
- No exposure to hypoxic environment, dehydration, heavy alcohol intake,

or severe exercise
- No trauma to chest

case4 checklist

History Taking including ROS:

- Asked about the location of pain
- Asked about the intensity of pain
- Asked about the quality of pain
- Asked about the origin and duration of pain
- Asked about the progression of pain
- Asked about any radiation of pain
- Asked about the aggravating factors
- Asked about the relieving factors
- Asked about any nausea and vomiting
- Asked about fever
- Asked about H/O cough and expectoration
- Asked about H/O hemoptysis
- Asked about H/O SOB/dyspnea
- Asked about precipitating factors of sickle cell crisis (such as diarrhea, dehydration, stress, exposure to an environment where u feel congested or felt short of breath?)
- Asked about history of chest trauma
- Asked about any leg pain/swelling/redness
- Asked about H/O blood in the urine
- Asked about H/O blood transfusion

Past Medical History:

- Asked about any similar problems in past
- Asked about past medical problems (other than sickle cell anemia such as high blood pressure, heart problems, H/o blood clots)
- Inquired about previous hospitalizations (surgery)

Allergies:

- Asked about history of allergies

FH:

- Asked about family history of Sickle cell anemia, heart problems, and blood clots

SH:

- Asked about smoking
- Asked about alcohol intake, especially recent heavy intake
- Asked any IV drug abuse

Obg/gyn:

- Asked about obg/gyn history
- Asked about sexual history
- Asked about occupation

Medications:

- Asked about my prescription and over-the-counter medications

Examination:

- Examinee washed hands
- Examined the oral cavity
- Examined for enlarged lymphnodes
- Performed inspection of the chest (redness and swelling)
- Performed the palpation of area (minimal attempt to disturb the patient, did not put stethoscope in the area of tenderness)

- Auscultated the lungs and heart
- Palpated abdomen superficially
- Palpated abdomen deeply
- Examined/inspected my fingers
- Examined the legs for tenderness (for DVT)
- Examined without gown not through the gown

Counseling:

- Explained the physical findings and diagnosis
- Explained the complications of disease (infections, hypoxia can precipitate the pain)
- Explained might have to take preventive vaccinations for H. influenzae
- Offered pain medications for time being
- Explained further work up (Blood tests, chest x ray)
- Explained the importance of avoiding hypoxemia and maintaining hydration

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact.
- Asked few open ended questions
- Asked non leading questions
- Asked one question at a time
- Listened to what ever I said with out interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances
- Asked whether I have any concerns/ questions.

D.D for this Case:

- Chest syndrome due to sickle cell anemia
- Pneumonia
- Costochondritis
- Pericarditis
- Pulmonary thromboembolism
- Salmonella osteomyelitis

Investigations:

- CBC with differential count; U/A
- Sputum Gram stain; Culture & Sensitivity
- Blood cultures
- Chest x ray
- ECG

CC: 29y/o BF, known patient of sickle cell anemia, complains of chest pain.

HPI:
A 29 y/o BF who has a H/O sickle cell anemia presents with central chest pain for 12 hours that started slowly and is progressively worsening. Pain is 7-8/10 in severity, sharp, worsened by movement and respiration and improves with OTC painkillers. She also C/O fever and chills for three days and cough productive of green colored sputum. Mild SOB is present. Denies nausea or vomiting or hemoptysis. No h/o blood transfusion, exposure to dehydration, high altitude or excessive exercise. No h/o chest trauma. Her LMP was two weeks ago. **ROS:** No GI or urinary complaints. **All:** None. **PMH:** Once hospitalized for abdominal pain when her sickle cell anemia was diagnosed. **Med:** OCPs and Tylenol. **FH:** Mother - sickle cell disease. No H/O blood clots in the family. **SH:** Teacher, denies smoking, ETOH, and IVDA. **SxH:** Single partner.

PE:
Vitals: P.R: 98/min; B.P: 120/75mm Hg; R.R 22/min; Temp: 101.3 F
Oral cavity: No erythema, or exudates. No enlarged lymphnodes. Chest: No redness or swelling, Normal rate and rhythm of breathing, trachea central, no accessory muscles used. No area of tenderness. Lungs are clear to percussion. On auscultation, normal vesicular breath sounds with no crackles, rales or wheezes. TVF is WNL. S1, and S2 +; No murmurs/rubs/gallops. Abdomen: S/NT/ND/BS+; No organomegaly. Extremities: No edema, calf tenderness, or swelling of the fingers .

D/D:
Chest syndrome due to sickle cell anemia
Pneumonia
Costochondritis
Pericarditis
Pulmonary thromboembolism
Salmonella osteomyelitis

Investigation:
CBC with differential; U/A
Sputum Gram stain; Culture & Sensitivity
Blood cultures
CXR
ECG

35-year-old male with recent onset cough

Vitals:

PR: 98/min, regular

BP: 120/75 mmHg

Temp: 38.3 C (101.0 F)

RR: 20/min

Differential diagnosis for recent onset Cough:

1. Common cold
2. Acute sinusitis
3. Allergic rhinitis
4. Acute bronchitis
5. Pneumonia
6. Pertussis
7. Pulmonary embolism
8. Drugs (ACE inhibitors)
9. Asthma

In elderly patients also consider:

1. Congestive heart failure
2. Chronic obstructive pulmonary disease (COPD) exacerbation

case5 SP

***If the doctor asks you anything other than these, just say 'no', or say things that are normal in daily routine life.**

1. You are Mr. Bill, age: 35-years, a paramedic, who drives an ambulance.
2. You came with complaints of cough for the past three days; it is a dry cough initially. You also have a cold, mild sore throat, sinus pressure, mild headache, and fever. You thought the symptoms would go away, but did not; and, in fact, they are getting worse. Now you get a teaspoonful of yellowish sputum each time you cough.
3. There is no blood in the sputum.
4. Cough is there all the time.
5. No breathing problem, no wheezing, and no chest pain.
6. You have tried Tylenol (acetaminophen) and cough suppressants; they gave some relief.
7. You have a history of sinusitis and asthma. Both are well controlled and you take albuterol puffs once in a while.
8. You are allergic to cats.
9. Father has a history of bronchial asthma. Your 8-year-old son is also sick.
10. Smoking – one pack per day for 15 years.
11. Occasionally takes alcohol.

case5 checklist

HPI:

- Asked about the onset of cough
- Asked about the duration of cough

- Asked whether it is dry or productive
- Asked me to describe about the sputum (color, quantity)
- Asked about any problem with breathing
- Asked about wheezing
- Asked about chest pain (pleuritic)
- Asked about history of fever and chills
- Asked about sinus congestion or pain over the sinuses
- Asked about headache
- Asked about rhinorrhea
- Asked about sore throat
- Asked about contacts with ill persons (workplace)

PMH:

- Asked about similar episodes in the past
- Asked about past medical problems (sinusitis, asthma, chronic allergies)
- Enquired about previous hospitalizations

SH:

- Asked about occupation
- Asked about smoking
- Asked about alcohol
- Asked about illicit drug intake

FH:

- Asked whether any other family members are sick (especially children)

ALL:

- Asked about history of allergies

Meds:

- Asked about my medications including over-the-counter

Examination:

- Washed hands before the examination
- Checked my nasopharynges and oropharynges
- Checked my neck for lymph nodes
- Palpated my sinuses
- Asked me to say 99 repeatedly (palpated for tactile vocal fremitus). SP

will say 99 slowly (or) loudly when it comes to the lower part of the lung to mimic pleural effusion or consolidation.

- Tapped on my lungs (percussion)
- Auscultated all over the lungs and heart
- Examined without gown, not through the gown

Counseling:

- Explained the physical findings and diagnosis
- Explained the further workup (blood tests, chest x-ray, sputum studies)
- Explained the importance of lifestyle modifications by quitting smoking and alcohol
- Advised me to take rest and acetaminophen, drink fluids, and humidification

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this Case:

- Common cold
- Acute sinusitis
- Acute bronchitis
- Pneumonia

Investigations:

- CBC with differential count
- Sputum gram stain and culture/sensitivity
- Chest x-ray, PA and lateral view

Note: Ask about history of prolonged travel, resent surgery, and use of oral contraceptive pills (in females) for pulmonary embolism – only if the patient has shortness of breath and cough, without any other upper respiratory infection symptoms. In the above patient, it is not required.

case5 Pt Notes

HPI: This is a 35-year-old male who presents with an illness characterized by dry cough, fever, rhinorrhea, and sore throat. Symptoms began 3 day(s) ago and are gradually worsening since that time. Now, he started to develop productive yellow cough. His 8-year-old child is also sick. Past history is significant for asthma, sinusitis, and tobacco abuse. **SH:** works as a paramedic; smokes 1PPDx15 years. ETOH: 1 beer/day for the last 5 years. **FH:** Father has asthma. **All:** cats. **Meds:** Albuterol MDI as needed.

Examination:
VS: BP 122/80 mmHg, PR 98/min, RR 18/min, and T 38.3C (101F).
General appearance: healthy, alert, no distress
Nose: no mucosal erythema, no mucosal edema and no purulent discharge
Oropharynx: exudates present and mild erythema (or) no erythema or exudates
Neck: Small, benign anterior cervical nodes bilaterally (or) supple, no lymphadenopathy
Lungs: expiratory wheezes and rhonchi throughout both lung fields (or) normal vesicular breathing with no crackles, rales, or wheezes.
Heart: regular rate and rhythm, no murmurs, clicks, or gallops.

D.D for this Case

- Common cold
- Acute sinusitis
- Acute bronchitis
- Pneumonia

Investigations:

- CBC with differential count
- Sputum gram stain and culture/sensitivity
- Chest x-ray, PA and lateral view

case6 Scenario

50-year-old male complaining of fatigue and loss of weight

Vitals:

1. PR: 78/min
2. BP: 120/76 mmHg
3. Temp: 98.0 F (36.7 C)
4. RR: 18/min

Make a mental checklist of DD for weight loss:

1. Malignancy
2. Diabetes mellitus
3. Hyperthyroidism
4. Depression
5. Infections like TB, HIV
6. Malabsorption
7. Addison's disease

case6 SP

If the doctor asks you anything other than these just say 'no,' (or) say things that are normal in daily routine life.

1. You are Mr. Albert, age: 50 years
2. Have generalized body weakness and fatigue for past 5 months.
3. Started slowly, progressively increasing fatigue.

<u>After the Doctor asked more about your complaint (or) any other complaints, you should tell about the abdominal discomfort.</u>

1. Noticed abdominal discomfort above the umbilicus, it is more like a gas;

stomach feels full with few bites of food.

2. No nausea/vomiting, no fever, no jaundice.
3. Appetite has reduced. Weight has reduced about 30 pounds in last 3 months.
4. Stools are normal brown in color. Sometimes they appear black, but never noticed blood.
5. No cough, breathing problem, chest pain, palpitations, swelling of the legs, or difficulty swallowing.
6. No problem with temperature, recently, but always feel hot. No tremors or sweating noted.
7. Has had constipation for several years on and off, but nothing is new.
8. No interest in life and other social activities.
9. Your sleep is decreased, gets up early in the morning.
10. Decreased energy; feelings of guilt present; decreased concentration.
11. Thought that life is not worth living. No longer feels interest in activities. However, never had a thought of suicide.
12. Lost your wife three months ago. You are more fatigued since the death of your wife.
13. No allergies.
14. Family health - Mother died from pancreatic cancer at the age of 60.
15. Have single sexual partner. Decreased libido. Never had multiple sexual partners.
16. Smoking – no.
17. Alcohol - takes couple of beers every day for the past 30 years.
18. Works at local restaurant and the workplace is not stressful.
19. No illicit drug intake.

case6 checklist

History taking including ROS:

1. Asked about the onset and progression of weakness/fatigue (complaint, open-ended question)
2. Any associated symptoms? (SP will tell about abdominal pain)

3. Asked about nausea and vomiting
4. Asked about fever, chills, and night sweats (constitutional symptoms)
5. Asked about any change in appetite
6. Asked about any change in weight
7. Asked about any blood in the stools or black stools
8. Asked about any shortness of breath/chest pain
9. Asked about any cough and hemoptysis
10. Asked about swallowing difficulty
11. Asked about any jaundice
12. Asked about thyroid problems (temperature intolerance, tremors, insomnia, palpitations)
13. Enquired about any precipitating factors
14. Asked about any constipation or diarrhea
15. Asked about any swollen glands or swelling in the neck
16. Asked about my mood (How is your mood?)
17. Asked about the interest in life
18. Asked about the energy level
19. Asked about any guilt feelings
20. Asked about sleep problems
21. Asked about any ideas, plans, attempts for suicide
22. Asked about change in libido
23. Asked about increase or decrease in motor activity

Past Medical History:

1. Asked about similar episodes in the past
2. Asked about the past medical problems (high blood pressure, diabetes, thyroid problems, peptic ulcer disease, pancreatic problems, heartburn)
3. Enquired about previous hospitalizations and surgeries

Allergies:

1. Asked about history of allergies

FH:

1. Asked about family history of cancer or depression

SH:

1. Asked about smoking
2. Asked about alcohol
3. Asked about IV drug abuse

4. Asked about sexual history, including high risk sexual behavior
5. Asked about occupation, any stress at home or work

Medications:

1. Asked about prescription and over-the-counter medications

Examination:

1. Examinee washed hands
2. Examined eyes
3. Examined oral cavity
4. Examined neck for thyromegaly and lymphadenopathy
5. Auscultated chest (heart and lungs)
6. Palpated abdomen, both superficially and deeply
7. Checked legs for edema
8. Checked muscle power
9. Looked for ankle jerk/reflex
10. Examined without gown, not through the gown

Counseling:

1. Explained the physical findings and probable diagnosis (hyperthyroidism, anemia, depression, grief reaction, any bowel disorder)
2. Explained further work-up (blood tests, thyroid profile, stool examination)
3. Inquired regarding need of any support groups and volunteered to refer to some of them

Communication Skills:

1. Knocked before entering the room
2. Introduced himself and greeted warmly
3. Used my name to address me
4. Paid attention to what I said and maintained good eye contact
5. Asked few open-ended questions
6. Asked non-leading questions
7. Asked one question at a time
8. Listened to whatever I said without interrupting me in between
9. Used lay man's language
10. Used appropriate transition sentences
11. Used appropriate draping techniques
12. Summarized the history and explained physical findings

13. Expressed empathy, made appropriate reassurances
14. Asked whether I have any concerns/questions

DD for this Case:

1. GI malignancy
2. Hyperthyroidism
3. Depression

Investigations:

1. Rectal exam and stool examination for occult blood
2. CBC with differential count
3. TSH
4. LFTs
5. Abdominal USG

case6 Pt Notes

CC: 50-year-old male with fatigue and loss of weight

HPI:
This is a 50-year-old previously healthy white male presenting with slowly, progressive fatigue over a period of 5 months and a 30 pound weight loss in the last 3 months. Other complaints include abdominal discomfort above the umbilicus, decrease in appetite, and early satiety. He also complains of loss of interest, terminal insomnia, and feeling of worthlessness. Three months ago, his wife died. Fatigue is worsened since the death of his wife. **ROS:** He denies any dysphagia, nausea, vomiting, jaundice, melena, blood in the stools, recent change in bowel habits, though he has a long history or altered bowel habits. He also denies fever, chills, night sweats, cough, hemoptysis, shortness of breath, chest pain, or leg swelling. He has no tremors, diarrhea, heat or cold intolerance. **PMH:** Nothing significant. **All:** None **Med:** None **FH:** Mother died from pancreatic cancer at age 60. **SH:** Restaurant manager. No history of smoking or IV drug abuse. Drinks a couple of beers daily for the past 30 years. **SxH:** Single sexual partner, c/o decreased libido. No history of high risk sexual behavior.

PE:
Vitals: PR: 78/min; BP: 120/75 mmHg; RR 22/min; Temp: 98.8 F (64.0 C). HEENT: No pallor, jaundice. Oropharynx is clear. Neck is supple, no thyromegaly or lymphadenopathy. Chest: CTA B/L. Normal S1, S2. No murmurs, gallops, or rubs. Abd: S/NT/ND/BS+/No organomegaly. Ext: No edema. Power is 5/5 in all 4 extremities. DTR: 2 +, symmetric.

D/D:
GI malignancy
Hyperthyroidism
Depression

Investigation:
Rectal exam and FOBT (Fecal Occult Blood Test)
CBC with differential
TSH
LFTs
Abdominal USG

case7 Scenario

35-year-old male with acute onset diarrhea

Vitals:

PR: 90/min, regular

BP: 100/60 mmHg

RR: 16/min

Temp: 98.0 F (36.7 C)

Make a mental checklist of DD for acute onset diarrhea:

1. Viral gastroenteritis
2. Bacterial gastroenteritis
3. Medication induced
4. Clostridium difficle colitis
5. Inflammatory bowel disease
6. Irritable bowel disease
7. Malabsorption
8. HIV

case7 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Mr. Smith, age: 35-years-old

2. Have diarrhea since yesterday
3. Started after eating seafood and a salad in a local restaurant
4. Bowel movements are 6-7 times a day; loose, watery, unformed bowel movements
5. There is a sensation of incomplete evacuation and pain (tenesmus)
6. Also have abdominal cramps, vomiting, and fever; all these started after diarrhea started
7. No blood or mucus in the stools
8. Your mom and dad are also sick but not as bad as you
9. You recently had sinusitis and have completed a course of amoxicillin 2 days ago
10. Never had this before
11. Feel very thirsty
12. No other medical problems except sinusitis
13. Never hospitalized and no surgeries
14. No change in urination
15. No allergies
16. No family history of diarrheal disease
17. Smoking – No
18. Alcohol - takes couple of beers every week
19. Occupation: Working as a computer programmer

case7 checklist

HPI:

- Please explain to me, what do you mean by diarrhea (increased frequency or increased volume or alteration of stool consistency)?
- Asked about the onset and duration of diarrhea (differentiate whether it is acute or chronic)
- Asked about the frequency of diarrhea
- Asked about associated symptoms (vomiting, fever, abdominal pain, anorexia, prior constipation, myalgia, and tenesmus)
- Asked which one is bothering most (is it diarrhea or nausea/vomiting)

- Asked about any blood or mucous in stools
- Asked about any recent travel, daycare contacts, or sexual exposure
- Asked whether any other family members are sick
- Asked about dietary history (unpasteurized or undercooked food, unusual foods, dairy products, seafood)

PMH:

- Asked about similar episodes in the past
- Asked about other medical problems (diabetes mellitus, HIV, GI bleeds, hyperthyroidism)
- Enquired about recent and previous hospitalizations
- Asked about any abdominal surgeries

SH:

- Asked about occupation
- Asked about alcohol intake

FH:

- Asked about family history of diarrheal diseases

All:

- Asked about known drug and food allergies

Meds:

- Asked about my medications
- Asked particularly about recent antibiotic use

*Ask about sexual history, in detail including contraception, if the index of suspicion for HIV is high. You do not need to ask this if the patient is more likely to have food poisoning. This is very important in chronic diarrhea.

Examination:

- Examinee washed hands
- Auscultated abdomen
- Palpated abdomen superficially
- Palpated abdomen deeply
- Examination of skin for any rashes
- Examination of oral cavity
- Respiratory examination

- Cardiac auscultation
- Examined without gown, not through the gown

Counseling:

- Explained the physical findings and differential diagnosis
- Explained further workup (blood tests, stool examination)
- Asked to perform rectal examination
- Advises me to take plenty of oral fluids

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this Case:

- Viral gastroenteritis
- Bacterial gastroenteritis
- Clostridium difficle diarrhea

Investigations:

- Rectal examination and FOBT
- CBC with differential count
- Basic metabolic panel (NA, K, Cl, Co2, BUN, Cr, glucose)
- Stool for Clostridium difficle toxin
- Stool for fecal leukocytes

case7 Pt Notes

HPI: This is a 35-year-old WM who presents with symptoms of cramping, vomiting, diarrhea, fever, and sweats. Symptoms started yesterday, gradually improving since that time. Ate outside with family. Symptoms started 6-8 hours later. Other family members affected - father and mother. No history of gastrointestinal disease. Also had received amoxicillin for sinusitis 10 days ago and completed the course 2 days ago. Rest of the ROS is negative. **PMH**: None. **SH**: School teacher; denies ETOH. **FH**: NS (nothing significant). **All**: None. **Meds**: None.

Exam:

VS: T 36.7 C (98 F), BP 110/65 mmHg, PR 110/min, and RR 28/min.
General appearance: healthy, alert; mucus membranes are dry
Oropharynx: normal
Lungs: clear to auscultation and percussion (CTA B/L)
Heart: normal, regular rate and rhythm, no murmurs, clicks, or gallops
Abdomen: S/NT/ND/hyperactive BS; no guarding or rigidity present. No organomegaly, and no masses felt

D.D for this Case:

Viral gastroenteritis
Bacterial gastroenteritis
Clostridium difficle diarrhea

Investigations:

Rectal examination and FOBT
CBC with differential count
Basic metabolic panel (NA, K, Cl, Co2, BUN, Cr, glucose)
Stool for Clostridium difficle toxin
Stool for fecal leukocytes

case8 Scenario

25-year-old female complains of sore throat

Vitals:

PR: 90/min, regular

BP: 120/70 mmHg

RR: 16/min

Temp: 101.0 F (38.3 C)

Make a mental checklist of DD for sore throat:

- Viral pharyngitis (rhino virus and influenza)
- Bacterial pharyngitis
    - Group A Streptococcal pharyngitis
    - Mycoplasma pneumonia
    - Neisseria gonorrhea
- EBV mononucleosis
- Postnasal drip secondary to rhinitis
- Chronic tonsillitis
- Primary HIV

case8 SP

***If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Miss Alexia, a 25-year-old college student
2. You came with complaints of sore throat for the past 3 days
3. Symptoms started with nasal stuffiness, headache, sore throat, dry cough, and fever
4. Tried over-the-counter Tylenol and Benadryl; gave some relief, but it is getting worse
5. Also have difficulty swallowing
6. Mild body aches and joint pains for the past 3 days
7. No history of rash
8. No abdominal or pelvic pain

9. Boyfriend had similar complaints 2 weeks back but recovered now
10. You also have similar episodes in the past, 2 times since childhood
11. Have chronic tonsillitis in the past but had not undergone surgery
12. No history of sinusitis
13. Never hospitalized
14. Sexually active only with boyfriend, using condoms regularly
15. College student
16. Smoking - No
17. Alcohol - No
18. Drugs - No
19. No known drug allergies

case8 checklist

HPI:

1. Asked about the onset of sore throat
2. Asked about the progression of disease
3. Asked about pain during swallowing
4. Asked about the cough and breathing problem
5. Asked about nasal discharge
6. Asked about pain over sinus areas (sinus congestion) and postnasal drip
7. Asked about headache
8. Asked about the fever and chills
9. Asked about nausea and vomiting
10. Asked about joint pains and muscle aches
11. Asked about swollen or enlarged neck glands
12. Asked about abdominal pain (left upper quadrant and pelvic pain)
13. Asked about any rash
14. Asked about vaginal discharge
15. Asked about contacts with ill persons

PMH:

1. Asked about similar episodes in the past

1. Asked about past medical problems (tonsillitis, sinusitis, diabetes)

SH:

1. Asked about occupation
2. Asked about smoking
3. Asked about alcohol

All:

1. Asked about any known drug allergies

Meds:

1. Asked about the medications that I tried

Examination:

1. Washed hands before examination
2. Looked inside mouth (Sometimes you may get a real case of enlarged tonsils, so do not over look it)
3. Palpated for enlarged neck glands
4. Examined both ears
5. Palpated for spleen (they may act like they are having some discomfort when you press your hand for spleen, so everyone must do this test for this case) and liver
6. Palpated abdomen gently and deeply
7. Auscultated heart
8. Auscultated lungs
9. Examined skin for rash
10. Examined without gown, not through the gown

Counseling:

1. Explained the physical findings and differential diagnosis
2. Explained further workup (throat swab, Mono spot test)

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions

- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this Case:

1. Infectious mononucleosis
2. Viral pharyngitis
3. Bacterial pharyngitis

Investigations:

1. CBC
2. Mono spot test
3. Rapid streptococcal antigen test

case08 Pt Notes

HPI: This is a 25-year-old female who presents for evaluation and treatment of sore throat. Symptoms include headache, sinus pressure, congestion, runny nose, sore throat, pain with swallowing, fever, and dry cough. Symptoms started 3 days ago, gradually worsening since that time. Her boyfriend had similar illness 2 weeks ago. She denies nausea, vomiting, SOB, abdominal pain, and vaginal discharge. Tried OTC (over-the-counter) Tylenol and Benadryl.
PMH: None. SH: College student; Smoking - No; ETOH - No. All: NKDA.

Examination:

VS: T 36.7 C (98 F), BP 110/65 mmHg, PR 110/min, and RR 16/min.
General: healthy, alert
Ears: R TM - normal, L TM - normal
Nose: no mucosal erythema, no mucosal edema, and no purulent discharge
Oropharynx: exudates present
Neck: small, benign anterior cervical nodes bilaterally
Lungs: CTA B/L
Heart: RRR; No murmurs, clicks, or gallops
Abdomen: S/NT/ND/No organomegaly.

case9 Scenario

56-year-old male for BP Check and refill of the medications

Vitals:

PR: 80/min

BP: 150/90 mmHg

Temp: 97.0 F (36.1 C)

RR: 16/min

Make a metal checklist of complications of BP:

- Diastolic congestive cardiac failure
- Coronary artery disease (angina)
- Peripheral vascular disease
- Retinopathy
- Side affects of the medications

case9 SP

***If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. John, age 56
2. High blood pressure for past 10 years
3. Is taking medications as prescribed regularly; takes propranolol 20 mg twice a day
4. No headaches
5. Never had palpitations
6. Never had blurred vision
7. No breathing problem, chest pain, palpitations, nose bleeds, dizziness or leg swelling
8. Is checking BP (self) regularly at home, usually 140-150 systolic and 80-90 diastolic
9. Your last cholesterol was checked 2 years ago and it was high; you don't

remember the exact number

10. Is not doing any exercise
11. No diet regulation
12. Family history of high BP (father)
13. Employment: works in food industry; no stress
14. Smokes 1 pack per day for 30 years
15. Occasionally takes alcohol (social drinking only)
16. No illicit drug use
17. Also have high cholesterol and takes simvastatin 40 mg at bedtime
18. No known drug allergies

case9 checklist

HPI:

- Asked about the onset of hypertension (When were you diagnosed with high blood pressure?)
- What medications have you been taking? Do you take them regularly as prescribed?
- Do you have any problems with the medications? (Propranolol-impotence; ACE inhibitor-cough)
- Do you get headaches?
- Do you feel dizzy?
- Have you had any nosebleeds?
- Do you have any breathing problem? (shortness of breath, orthopnea, PND)
- Have you had any palpitations?
- Have you had any chest pain or pressure?
- Have you noticed any leg swelling?
- Do you check your blood pressure regularly? How often? Do you remember the range?
- Can you tell me about your diet?
- Do you exercise regularly?
- When did you have your cholesterol checked the last time? What was it?

PMH:

- Do you have any other medical problems?

SH:

- Asked about occupation and related stress
- Asked about smoking history
- Asked about alcoholism
- Asked about illicit drug use

FH:

1. Asked about family history of premature coronary artery disease, hypertension, and strokes

Allergies:

1. Asked about any known drug allergies

Examination:

- Informed me
- Washed hands
- Recorded BP from both arms
- Examined eyes with ophthalmoscope
- Examined neck for bruit and JVD (JVP)
- Auscultated heart
- Auscultated lungs
- Palpated for carotid, radial, posterior tibialis pulses
- Examined without gown, not through the gown

Counseling:

- Complemented me for using medications as prescribed
- Complemented me for checking the BP regularly
- Explained the workup needed
- Explained the importance of sodium restricted diet and regular exercise
- Explained likely complications of uncontrolled BP

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact

- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D:

1. Essential hypertension follow-up

Investigation:

- Urinalysis
- Lipid profile

1. ALT

HPI: This is a 56 y/o WM who presents for evaluation of hypertension. HTN was diagnosed 10 years ago and has been on propranolol. Patient denies any side effects of medication. He states that he is feeling well and denies any symptoms referable to his high blood pressure; specifically denies chest pain, palpitations, dyspnea, orthopnea, PND or peripheral edema. **PMH**: 1. Hypercholesterolemia 2. HTN. **FH**: Father has HTN. **SH**: works in food industry; no stress; Smokes 1 ppdx30 yrs; ETOH-occasional; No IVDA. **All**: NKDA. **Med**s: 1. Propranolol 20 mg po BID. 2. Simvastatin 40 mg po QHS (at bed time).

Exam:
VS: BP 122/80 mm Hg, PR 98/min, RR 16/min, and T 38.3C(101F).
Repeat BP R arm seated = *** L arm seated = ***.
Fundi: no hemorrhages or exudates and no AV crossing changes.
Neck: supple, no masses, no JVD, no bruits and thyroid normal
Lungs: Clear to auscultation and percussion (CTA B/L)
Heart: PMI normal. No lifts, heaves, or thrills. RRR. No murmurs, clicks or rubs
Peripheral pulses: Normal and full, radial=2/4, femoral=2/4, popliteal=2/4, post tib=2/4, dorsalis pedis=2/4

D.D:
Essential hypertension follow-up

Investigations:
Urinalysis
Lipid panel
ALT (for statin side affects – abnormal LFTs)

case10 Scenario

66-year-old male complaining of constipation

Vitals:

PR: 70/min, regular

BP: 120/70 mmHg

RR: 16/min

Temp: 98.0 F (36.7 C)

Make mental checklist for constipation:

- Functional constipation
- Obstructive lesions (bowel obstruction, carcinoma of colon)
- Metabolic disturbances (hypothyroidism, diabetes mellitus, hypercalcemia)
- Neurologic dysfunction (stroke, autonomic neuropathy, spinal cord trauma, multiple sclerosis, and Parkinson's)
- Medication induced (iron preparations, opiates, anticholinergics)

case10 SP

***If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Mr. Jansen, age: 66 years
2. Have constipation on and off for the last 5 months, and it is getting worse for the past 2 months
3. Have difficulty passing stools. They are not painful, but you have to strain a lot. The stool caliber is okay, but they are hard.
4. There is a sensation of incomplete evacuation.
5. Never noticed blood in the stools; but, once in a while, black stools are seen
6. Do not have episodes of diarrhea in-between
7. No abdominal pain; no nausea or vomiting
8. You have lost a lot of weight in the past 2 months. Appetite is reduced, too
9. You feel fatigued

10. You never had this before
11. You also have severe knee pain from degenerative joint disease, and you were recently started on oxycodone (narcotic) 2 months ago for pain control
12. You drink enough water but that has only increased frequency of urination. Your diet mainly has vegetables and very little bacon
13. Have a history of Hashimoto's thyroiditis and on thyroxine replacement
14. No history of diabetes
15. Never hospitalized and never had any surgeries done
16. Father died of colon cancer at 67
17. You never had screening colonoscopy, but you had rectal exam done 2 years ago
18. No allergies
19. No other medications
20. Smoking – No
21. Alcohol- takes 2-3 glasses of wine every week
22. Occupation: Working as a supervising technician in a pharmaceutical company

case10 checklist

HPI:

- Asked an open-ended question ‘what do you mean by constipation? Can you please explain to me more about it?’
- Asked about the onset of constipation
- Asked about the frequency of bowel movements
- Asked about amount and caliber of stool passed
- Asked about consistency of stool
- Asked about pain during defecation
- Asked about any blood in stools or black stools
- Asked about episodes of diarrhea in-between
- Asked about any nausea and vomiting
- Asked about abdominal pain or cramps
- Asked about urinary problems (polyuria, dribbling)
- Asked about problems adjusting to temperatures

- Asked about loss of appetite and weight loss
- Asked about my diet (fiber diet; Do you drink a lot of fluids?)

PMH:

- Asked about similar episodes in the past
- Asked about other medical problems (diabetes, thyroid problems, neurologic problems)
- Enquired about previous hospitalizations and surgeries
- Asked whether I had regular screening procedures, like annual rectal exam and screening colonoscopy

SH:

- Asked about occupation
- Asked about smoking
- Asked about alcohol

FH:

- Asked about family history of colon cancer

All:

- Asked about history of allergies

Meds:

- Asked about my medications in detail and when they started and any recent changes made

Examination:

- Examinee washed hands

1. Examined eyes for pallor
2. Auscultated abdomen
3. Examined abdomen superficially

- Examined abdomen deeply
- Checked muscle power and reflexes in lower extremities
- Examined without gown, not through the gown

Counseling:

- Explained the physical findings and differential diagnosis
- Explained further workup (Blood tests, rectal examination, stool test for

blood, and colonoscopy)

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this Case:

- Medication induced
- Carcinoma of colon
- Uncontrolled hypothyroidism
- Functional constipation
- Undiagnosed diabetes

Investigations:

- Rectal examination and stool for occult blood
- CBC with differential
- Serum calcium
- TSH
- Fasting blood sugar and HbA1c
- Colonoscopy

50-year-old male complaining of impotence

Vitals:

PR: 80/min, regular

BP: 150/80 mmHg

RR: 16/min

Temp: 98.0 F (36.7 C)

Make mental checklist for Impotence:

- Diabetic neuropathy
- Atherosclerotic vascular disease
- Anxiety and other psychiatric disorders
- Medications, like antihypertensives
- Chronic alcoholism
- Pituitary dysfunction
- Spinal cord dysfunction

case11 SP 

***If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are not able to get erections for the past 3-4 months. It is gradual in onset.
2. Desire to do sex is present all the time
3. Aggravated by - stress
4. No associated problems
5. No previous episodes of sexual dysfunction
6. Sometimes you have problem with nocturnal erections
7. No pain in the legs or thighs; no headaches
8. You have your wife and no other sexual partners
9. No previous treatment/evaluation
10. Have had diabetes for past 10 years, maintaining with exercise, diet, metformin, and glipizide. You check your blood sugar twice daily and it is around 120-200, usually.
11. You also have high blood pressure and take propranolol; it was started 4

months ago

12. You also have had a generalized anxiety disorder for the past 5 years for which you are taking buspirone
13. Never hospitalized; no history of trauma
14. Never had any surgeries
15. No other medications
16. Smoking occasionally
17. Alcohol 2-3 beers/day for 25 years
18. Working as a truck driver

case11 checklist

HPI:

1. Asked an open-ended question ("Are you experiencing problems with sexuality?")
2. Asked about the onset
3. Asked about whether it is continuous (or) intermittent
4. Asked whether it is continuously getting worse
5. Asked about any problems of sexual desire
6. Asked about any problem of ejaculation
7. Asked about the number of sexual partners (if multiple, ask follow up question - Does the dysfunction occur with one partner and not another?)

1. Asked detailed sexual history (Who is the partner? Any conflicts/misunderstandings)

1. Asked about nocturnal erections
2. Asked aggravating factors
3. Asked about any pain in the legs (claudication)
4. Asked about anxiety and depression
5. Asked about headache (pituitary tumors)
6. Asked about trauma to spine

PMH:

1. Asked about other medical problems (hypertension, diabetes mellitus, sickle cell disease, pulmonary vascular disease)

2. Asked about any surgeries, particularly abdominal and pelvic

SH:

1. Asked about occupation
2. Asked about smoking
3. Asked about alcohol

Meds:

1. Asked about medications (particularly blood pressure meds, such as propranolol)

Examination:

1. Washed hands
2. Informed me
3. Examine abdomen for bruit
4. Palpated abdomen gently
5. Examined pulsations in lower limbs
6. Visual field examination if pituitary mass is suspected (if the patient also has headache)

Counseling:

1. Explained the workup and differential diagnosis
2. Advised me to strict diabetic diet
3. Advised me the importance of exercise program and quitting alcohol and smoking

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences

- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this Case:

- Medication induced
- Diabetic neuropathy
- Atherosclerotic vascular disease
- Anxiety

Investigations:

1. Rectal and genital examination
2. Fasting blood sugar and HbA1C
3. CBC
4. Nocturnal penile tumescence testing
5. TSH, serum prolactin, and testosterone, as needed

case12 Scenario 

Mother of 1 Yr. O/Baby With Fever

Make a mental note of differential diagnosis of fever

- Respiratory tract infections
- Ear infections
- Exanthematous diseases
- Meningitis
- Urinary tract infections
- Gastroenteritis

case12 SP 

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mrs. Smith, age: 26 yrs

- The 1-year-old baby is at home. Baby has fever since two days.
- It is high grade and the baby shakes once in a while but she is not drowsy or lethargic
- It never touched normal
- It responds to Tylenol
- The baby has not been feeding since two days.
- There is discharge from nose and ear. (Green in color)
- The baby has been coughing since one day and breathing very fast since then
- The baby has been passing yellow urine. And cries when he passes urine
- Vomited twice which is purely the ingested food
- No bowel problems
- There has been one episode when baby has tremors
- The whole body was jerking rhythmically and similarly on both sides
- During the episode the baby lost urine
- After the episode baby remained silent and irritable for a while then slept
- You have been using cold water tepid sponging
- The baby has completed all the required immunization
- The baby has been doing well in growing.
- The baby can stand on his feet
- Can say dada mama can hold things with his hand.
- The baby was born at full term No complication in delivery.
- The baby was breast-fed till 2 months and then formula was started.
- There is no history of recent travel.
- No history of rashes
- No history of exposure to any child with similar complaints.
- Elder siblings are doing well. No contacts with ill people

case12 checklist

History Taking (General Proforma)

- Asked about onset of fever, type
- Asked about progression, association with chills, does it touch baseline, responds to any medications

- Asked about association with any episode of seizures
- Asked about description of seizure (onset, spreading, associated with any incontinence of urine, bowel)
- Asked about what happened after seizure, whether child was irritable, was any part paralyzed
- Asked about any cough, ear discharge, nasal discharge, pain any where,
- Asked about vomiting
- Asked about urine, and bowel problems
- Asked about any exposure to infected individuals, any history of travel
- Asked about rashes
- Asked about motor, social development
- Asked about immunization history
- Asked about Prenatal, perinatal and postnatal history
- Asked about the feeding habits

Past History

- Asked about similar episodes in the past
- Asked about history of allergies
- Asked about past medical problems (ear infections, convulsions, urinary tract infections,)
- Enquired about previous hospitalizations
- Asked about family health and family h/o convulsions

Counseling

- Explained the differential diagnosis (fever due to infection of respiratory tract or ear or both, could be due to urinary tract infection, seizure is benign and due to fever)
- Explained the importance of child being here .
- Explained further work up (Blood tests, urinalysis, stool test)
- Meanwhile advise her to give fluids and antipyretics

Communication Skills

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact.
- Asked few open ended questions
- Asked non leading questions

- Asked one question at a time
- Listened to what ever I said with out interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances
- Asked whether I have any concerns/ questions.

D.D for this Case

- Febrile Seizures
  - Meningitis
  - Acute Otitis Media with Intracranial Spread
  - Acute Urinary Tract Infection

Investigations

- CBC with differential count and ESR
- Urinalysis
- Ear examination
- Fundoscopy
- Lumbar puncture

case13 Scenario 

45-year-old female complaining of acute, right upper quadrant abdominal pain

Vital signs:

PR: 100/min

Temp: 101.0 F (38.3 C)

RR: 20/min

BP: 130/80 mmHg

Make a mental checklist of DD for RUQ abdominal pain:

1. Acute cholecystitis
2. Biliary colic
3. Acute hepatitis
4. Perforation of peptic ulcer
5. Acute pancreatitis (biliary pain)
6. Right lower lobe pneumonia
7. Myocardial infarction
8. Congestive hepatomegaly
9. Hepatic abscess
10. Retrocecal appendicitis

case13 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Mrs. Debbie, age: 45 years
2. Have abdominal pain for the past two hours
3. Started suddenly, progressively increasing
4. 8-9/10 in severity
5. Right upper quadrant
6. It is a stabbing type of pain
7. Going to back of the scapula
8. Began after eating a large meal
9. Moving around, taking a deep breath, makes it worse
10. No alleviating factors
11. Associated with two episodes of vomiting
12. Vomit contains food, but no blood
13. Previous history of occasional black stools present
14. Feeling warm, no jaundice, no cough, no breathing problem, no chest pain
15. Similar severe abdominal pain five months ago; resolved spontaneously in few hours. In general, two to three hours after eating you get

epigastric pain. Usually relieves with eating snacks and taking antacids.

16. Had peptic ulcer in the past and was treated five years ago; don't remember the name of the medication
17. Hospitalized for delivery
18. Family history is unremarkable
19. Smoking - one pack per day for 20 years
20. Alcohol - two to three beers daily for past 15 years
21. Occupation - housewife; not working outside
22. Eats many fatty foods
23. No allergies
24. Taking antacids for pain relief

case13 checklist

HPI:

1. Asked about the location of pain
2. Asked about the intensity of pain
3. Asked about the quality of pain
4. Asked about the onset and duration of pain
5. Asked about the precipitating factors
6. Asked about the progression of pain
7. Asked about any radiation of pain
8. Asked about the aggravating factors
9. Asked about the relieving factors
10. Asked about nausea and vomiting
11. Asked about fever and chills
12. Asked about cough and breathing problems
13. Asked about any chest pain
14. Asked about jaundice
15. Asked about history of black stools

PMH:

1. Asked about similar episodes in the past
2. Asked about past medical problems (acid peptic disease, gall stones,

heart problems)

3. Enquired about previous hospitalizations (especially, gall bladder removal or appendectomy)

SH:

1. Asked about occupation
2. Asked about smoking
3. Asked about alcohol
4. Asked about diet

FH:

1. Asked about family history of gall stones

All:

1. Asked about history of allergies

Meds:

1. Asked about my medications

Examination:

1. Examinee washed hands
2. Informed me
3. Auscultated abdomen before palpation
4. Palpated abdomen superficially
5. Palpated abdomen deeply
6. Checked rebound tenderness and rigidity
7. Percussed for liver span
8. Elicited Murphy's sign
9. Auscultated lungs
10. Examined without gown, not through the gown

Counseling:

1. Explained the physical findings and differential diagnosis
2. Explained further workup (blood tests, ultrasound, chest x-ray, EKG, pancreatic enzymes)
3. Explained the importance of lifestyle modifications by quitting smoking, alcohol, and healthy diet.

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this Case:

1. Acute cholecystitis
2. Biliary colic
3. Perforation of peptic ulcer
4. Pancreatitis
5. Acute hepatitis

Investigations:

1. CBC with differential count
2. EKG
3. Chest x-ray
4. Ultrasound abdomen
5. Serum amylase and lipase
6. LFTs (albumin, AST, ALT, alkaline phosphatase, total and direct bilirubin)

24 Yr. O/F Came for prenatal visit for the first time

Vitals

- Pulse--78/min
- B.P--120/75 mm of Hg
- Temp-98.8F
- R.rate--22/min

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- Your last menstrual period was 12 weeks ago
- Pregnancy was confirmed 6 weeks ago at home and hospital
- This is your first pregnancy
- You have not felt fetal movements yet
- You don't have any H/O abortions
- No H/O sexually transmitted diseases in the past
- Your first menstrual period was at the age of 13 yrs, periods were regular, each cycle last for 4 to 5 days
- No H/O -
- Morning sickness/vomitings
- Abdominal pain
- Vaginal bleeding
- Fever
- Rash
- Breathing problem
- Swelling of feet
- You don't have any other medical problems
- No H/O blood transfusions in the past
- You don't have any family history of birth problems in your family
- No H/O urinary or bowel related problems
- You smoke cigarettes 1 pack per day since 5 yrs
- You drink 1 beer per week since 3 yrs
- Not taking any drugs
- You are having adequate sleep
- Not working since last month
- Your husband is very co-operative with you
- Taken rubella immunization long back.

case14 checklist

History taking (General Proforma)

- Asked about LMP
- Asked about how do I know about pregnancy.
- Asked about obstetrical history (pregnancy and abortions)
- Asked about my gynecologic history (Menarche, regular periods, contraception)
- Asked about any problems of pregnancy (vomiting, fever, abdominal pain, vaginal bleeding)

Past History

- Asked about any past medical problems like hypertension, diabetes and renal disease.
- Asked about history of allergy and exposure to cats
- Asked about rubella immunization in the past
- Asked about previous heart problems
- Asked about any urinary problems
- Asked about changes in bowel movements
- Asked about sleep
- Asked about families health (Congenital or birth problem in the family)
- Asked about diet and appetite
- Asked about smoking
- Asked about alcohol consumption
- Asked about any medication and illicit drugs (Caffeine) used/using
- Asked about working environment (for stress)
- Asked about history of sexually transmitted diseases
- Asked about previous Blood transfusions

Examination

- Examined my eyes (for pallor)
- Examined Oral cavity (For general hygiene)
- Examined Legs (for edema and varicose veins)
- Auscultated Heart and Lungs
- Examined and Auscultated abdomen (If less than 28 weeks just do Fundal grip; If more than 28 weeks do all the Leopold's maneuver's)

Counseling

- Explained the findings and told me further work up (Blood for Hb, TORCH screen, HIV (took the consent) , Hepatitis Screen, U/A, abdominal Sonogram)
- Advised me to stop usage of tobacco and alcohol consumption.
- Advised for safe sexual practices.
- Explained the need for vitamins, Iron supplementations and nutritious diet.
- Explained the importance of regular antenatal visits.

Investigations

- CBC with differential count, Blood grouping and typing
- Urine Analysis
- Ultrasound of Abdomen
- TORCH Screening
- Hepatitis B Screening
- HIV Screening

case15 Scenario 

60-year-old male complaining of acute shortness of breath

Vitals:

PR: 90/min

BP: 110/70 mmHg

Temp: 98 F (36.7 C)

RR: 26/min

Make a mental checklist for acute shortness of breath:

1. Pulmonary embolism
2. Congestive heart failure
3. Chronic obstructive pulmonary disease exacerbation
4. Pneumonia
5. Spontaneous pneumothorax
6. Bronchial asthma
7. Anxiety and panic attacks

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

- You are Mr. Adam, age: 60 years and have had shortness of breath (SOB) for the past two days
- You are very healthy; but, for the past year, you have had some shortness of breath with strenuous work; but, for the past two days, it is completely different.
- You are having some trouble breathing at nighttime and you have to use two pillows. No wheezing.
- SOB is aggravated by lying down and mild to moderate exertion
- Relieved by sitting and rest
- You also noticed swelling of your feet and ankles at the end of the day, but they usually are normal in the early morning
- No history of chest pain or fatigue
- Never heard of racing of your heart (palpitations)
- No history of fainting attacks
- Occasional dry cough; no fever or chills
- No leg swelling or pain
- No similar problems in the past
- No allergies
- No history of bronchial asthma or any lung disease
- Had high blood pressure for 20 years; taking atenolol 25 mg once a day.
- Recently had undergone back surgery for spinal fusion and stayed in the hospital for one week
- Family history - father died because of heart attack at the age of 60
- Smoking - one pack per day for past 30 years
- Alcohol - one glass of wine/day for past 15 years
- Occupation - Working as a fire fighter

case15 checklist

HPI:

1. Asked about the onset of the shortness of breath
2. Asked about the progression of the shortness of breath
3. Asked about chest pain
4. Asked about paroxysmal nocturnal dyspnea
5. Asked about orthopnea
6. Asked about wheezing
7. Asked about cough and expectoration
8. Asked about fever and chills
9. Asked about palpitations
10. Asked about syncope
11. Asked about recent travel or prolonged immobilization (recent surgery)
12. Asked about leg pain and swelling

PMH:

1. Asked about similar episodes in the past
2. Asked about past medical problems (high blood pressure, other heart problems, asthma, and chronic obstructive pulmonary disease)
3. Enquired about previous hospitalizations

SH:

1. Asked about occupation
2. Asked about smoking
3. Asked about alcohol

FH:

1. Asked about family history of blood clots and heart problems

Meds:

1. Asked about my medications
2. Asked about medications and compliance

All:

1. Asked about history of allergies

Examination:

1. Examinee washed hands
2. Performed eye examination with ophthalmoscope
3. Looked for elevated jugular-venous pressure
4. Palpated for PMI
5. Listened to my heart
6. Auscultated all over the lungs
7. Checked for pedal edema
8. Checked peripheral pulses
9. Checked calf muscle tenderness
10. Examined without gown, not through the gown

Counseling:

1. Explained the physical findings and diagnosis
2. Explained further workup (blood tests, chest x-ray, EKG, and echocardiogram)
3. Explained the importance of lifestyle modifications by quitting smoking, alcohol, and exercise program

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to what ever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/ questions

D.D for this Case:

1. Pulmonary embolism
2. Congestive heart failure
3. Chronic obstructive pulmonary disease

Investigations:

1. CBC with differential count
2. Chest x-ray
3. EKG, 12 lead
4. V/Q scan
5. Echocardiogram
6. Pulmonary function tests, as needed

case16 Scenario 

40-year-old female with increased urination

Vitals:

PR: 86/min, regular

BP: 110/70 mmHg

RR: 16/min

Temp: 98.0 F (36.7 C)

Make a mental checklist of DD for polyuria:

- Diabetes mellitus
- Central diabetes insipidus
- Nephrogenic diabetes insipidus
- Psychogenic Polydypsia
- Cystitis (Urinary Tract Infection)
- Diuretics and other drug intake
- Hypercalcemia

case16 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

- You are a 40-year-old female feeling tired for the past 2 months
- Increasing day by day
- You also have increased urination-8-10 times/day
- 2-3 times in nights
- Also have increased volume of urine
- No burning urination, no urgency
- Also have increased thirst - 1 month
- Drinking a lot of water and eating a lot these days
- You have also lost 10 lbs of weight during the last 3-4 months
- You have a history of minor trauma to your head 3 months back; just admitted, and later discharged from the hospital without any intervention
- No similar problems in the past
- No history of diabetes
- No smoking, no alcohol consumption history
- Occupation – homemaker and no stress at work
- Not taking any other drugs, including recreational drugs
- Both father and mother have diabetes
- No known drug allergies
- Your only other medical problem is bipolar disorder and have been taking lithium for years

case16 checklist

HPI:

- Asked about the onset of problem
- Asked about the frequency of urination
- Asked about the nocturia
- Asked about the volume

- Asked about the burning urination
- Asked about the urgency and hesitancy
- Asked about the thirst
- Asked about the water intake
- Asked about the weight changes
- Asked about the appetite
- Asked about the trauma to the head
- Asked whether I have any other symptoms other than polyuria

PMH:

- Asked about the similar problems in the past
- Asked about other medical problems
- Asked about the psychiatric problems (history of bipolar disorder, schizophrenia)

SH:

- Asked about occupation
- Asked about smoking
- Asked about alcohol

FH:

- Asked about family history of diabetes

All:

- Asked about known drug allergies

Meds:

- Asked about the my medications

Examination:

- Washed hands
- Examined mucus membranes
- Auscultated heart
- Tested muscle power in both upper and lower limbs
- Tested sensations in lower extremities
- Tested reflexes in lower extremities
- Tested visual fields and examined fundus

- Tested for suprapubic tenderness
- Examined without gown, not through the gown

Counseling:

- Explained the physical findings and differential diagnosis
- Explained further workup (blood tests, urine tests)

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this Case:

- Diabetes mellitus
- Central diabetes insipidus
- Nephrogenic diabetes insipidus
- Psychogenic polydypsia
- Hypercalcemia

Investigations:

- Fasting blood sugar
- Urinalysis
- Serum electrolytes (Na, K, Cl, Co2, BUN, Cr, and Calcium)
- Urine and serum osmolality

case17 Scenario

35 Yr. O/F Came for evaluation of jaundice

Vitals

- Pulse--98/min
- B.P--120/75 mm of Hg
- Temp-101.3
- R.rate--22/min

Make a mental checklist of Differential Diagnosis for jaundice

- Infectious hepatitis
- Hemolytic jaundice
- Alcoholic hepatitis
- Drug induced hepatitis
- Primary biliary cirrhosis
- Wilson's disease
- Hemochromatosis
- Malignancy

case17 SP

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mrs. Catherine, age: 35yrs a house wife.
- You came with complains of fever with chills since 5days.
- You have noticed yellowish discoloration of eyes since 2 days.
- You noticed pale colored stools and dark urine since 3 days.
- There is a mild discomfort in the belly from a day.
- Traveled to India and came back 20 days back.
- Had blood transfusions 2 yrs ago for an accident (Trauma to legs). Has been hospitalized
- No History of sore throat, Bleeding, or any enlarged glands.
- No similar episodes in the past.
- No specific allergies.

- No history of high blood pressure, diabetes, hepatitis, liver disorders.
- Appetite has decreased, there is no weight loss.
- No problems with urinary and bowel habits.
- Not a smoker. Consumes 3 beers / day since 20yrs
- Took medication for fever. Did not take Hepatitis B vaccine.
- Sexual history is fine and only with husband. Using condoms as contraception
- No significant family history.

Ask this qt "Doc is it a hepatitis?"

case17 checklist

History Taking (General Proforma)

- Asked about the onset of Jaundice
- Asked about the duration of Jaundice
- Asked about the color of stools and urine
- Asked about itching/pruritis
- Asked about abdominal pain.
- Asked about fever with chills.
- Asked about sore throat
- Asked about any bleeding tendencies
- Asked about enlarged glands
- Asked about travel history

Past History

- Asked about similar episodes in the past
- Asked about history of allergies (For any animals, food, drugs etc)
- Asked about past medical problems (Hepatitis, liver disease, blood transfusions, high blood pressure, diabetes)
- Enquired about previous hospitalizations
- Asked about urinary and bowel problems
- Asked about family health
- Asked about smoking
- Asked about alcohol
- Asked about illicit drug intake

- Asked about sexual history
- Asked about weight changes

Examination

- Examinee washed hands
- Auscultated abdomen
- Palpated abdomen superficially
- Palpated abdomen deeply
- Checked rebound tenderness
- Palpated liver
- Palpated spleen
- Examined for enlarged nodes
- Examined without gown not through the gown

Counseling

- Explained the physical findings and diagnosis
- Explained further work up (Blood tests, liver function test , hepatitis screen)
- Explained the importance of lifestyle modifications by quitting alcohol.

Communication Skills

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact.
- Asked few open ended questions
- Asked non leading questions
- Asked one question at a time
- Listened to what ever I said with out interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances
- Asked whether I have any concerns/ questions.

D.D for this Case

- Infectious hepatitis
- Alcoholic hepatitis

- Drug induced hepatitis
- Primary biliary cirrhosis
- Malignancy

Investigations

- CBC with differential
- Urine for bile salts
- Anti mitochondrial antibodies
- LFTs
- Hepatitis screen.

case18 Scenario 

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35 Yr. O/F Complaining of Chest Pain

Vitals

- Pulse--98/min
- B.P--120/75 mm of Hg
- Temp-101.3
- R.rate--22/min

Make a mental checklist of Differential Diagnosis.

If a young adult female comes with chest pain think of non cardiac causes first because that is the one that you are going to get in the exam.

- Pneumonia
- Gastro esophageal reflux disease (GERD)
- Panic disorder
- Hyperthyroidism
- Pheochromocytoma
- Hyperventilation syndrome
- Angina
- Costochondritis

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mrs. Luis, age: 35yrs
- Have episodes of chest pain since 2 yrs
- Progressively increasing number of episodes
- Usually the episodes are 4-5/10 in severity,
- All over the chest,
- Its a type of tightness and squeezing in quality.
- No radiation
- No aggravating and alleviating factors
- Not associated with vomiting and sweating
- Have hyperventilation, diaphoresis, dizziness and its a kind of fear of dieing and sense of terror
- 5 episodes of similar problems in the past each lasts around 20 mts
- You also have headache during the episodes.
- You are not able to predict them and you are worried to go out because they are coming most of the times when you go out.
- No allergies.
- Hospitalized 2 times previously for evaluation and you didn't find out what exactly is the problem
- No Urinary or bowel problems
- Family's health - mother had hypochondriac disorder
- You don’t have any family conflicts and other problems
- Obg/gyn - normal
- Smoking - 1 pack per day for 8 yrs
- Normal sleep
- Alcohol - no
- Occupation - Working as a Red Cross member
- Appetite and wt is normal
- Diet - normal.
- Tried antacids but didn't give any relief

- No illicit drug intake (cocaine) and other drugs

case18 checklist

History Taking (General Proforma)

- Asked about the location of pain
- Asked about the intensity of pain
- Asked about the quality of pain
- Asked about the origin, duration and frequency of pain
- Asked about the progression of pain
- Asked about any radiation of pain
- Asked about the aggravating factors.
- Asked about the relieving factors
- Asked about any precipitating factors
- Asked about any vomiting, sweating, hyperventilation and palpitations
- Asked about a fear of dying and a sense of terror
- Asked about cough
- Asked about syncope and dizziness.
- Asked about headache

Past History

- Asked about similar episodes in the past
- Asked about history of allergies
- Asked about past medical problems (high blood pressure, other heart problems, diabetes, thyroid problems)
- Enquired about previous hospitalizations
- Asked about urinary and bowel problems
- Asked about family health.
- Asked about appetite and changes in weight
- Asked about smoking
- Asked about alcohol
- Asked about Obg/gyn
- Asked about occupation and stresses in life .
- Asked about illicit drug intake and other drugs

Examination

- Examinee washed hands

- Listened my heart
- Auscultated all over the lungs
- Examined without gown not through the gown

Counseling

- Explained the physical findings and diagnosis
- Explained further work up (Blood tests)
- Explained the importance of lifestyle modifications by quitting smoking, behavioral relaxation)
- Advised not to avoid places where I have problems

Communication Skills

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact.
- Asked few open ended questions
- Asked non leading questions
- Asked one question at a time
- Listened to what ever I said with out interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances .
- Asked whether I have any concerns/ questions.

D.D for this Case

- Panic disorder
- Hyperthyroidism
- Pheochromocytoma
- Hyperventilation syndrome
- Angina

Investigations

- CBC with differential count
- EKG
- Chest X-Ray

- Thyroid profile
- Lipid profile (premature arteriosclerosis)
- Urinary Catecholamines

case19 Scenario 

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45 Yr. O/M complaining of Rt lower abdominal pain

Vitals

- Pulse--100/min
- Temp--98.7
- R.Rate--20/min
- B.P--130/80 mm of Hg.

Make a mental check list for Rt Lower Quadrant abdominal painin a male pt

- Appendicitis
- Meckel's diverticulitis
- Perforated viscus
- Intestinal obstruction
- Yersinia enterocolitica
- Pancreatitis
- Urolithiasis
- Even acute cholecystitis

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mr. Evan, age: 45yrs
- Have abdominal pain since 2 hrs,
- Started suddenly, progressively increasing,
- 8-9/10 in severity,
- Right behind the umbilicus
- It's a type of sharp pain.
- Going to RT side of my lower abdomen
- Began after eating a large meal
- Moving around makes it worse
- No alleviating factors
- Associated with 2 episode of vomiting and sweating
- Vomit contains yesterday food, no blood
- No Urinary or bowel problems ,last defecation was 20 hrs back
- No fever,
- No similar problems in the past,
- No allergies.
- Had peptic ulcer in the past and was treated 10 yrs ago
- Never hospitalized
- Family's health normal
- Smoking – 1 pack per day for 20yrs
- Alcohol- 3 beers daily since 15 yrs
- Occupation: Working as a bus driver
- Appetite and wt is normal
- No illicit drug intake (cocaine)

case19 checklist

History Taking (General Proforma)

- Asked about the location of pain
- Asked about the intensity of pain
- Asked about the quality of pain
- Asked about the origin and duration of pain
- Asked about the progression of pain
- Asked about any radiation of pain
- Asked about the aggravating factors.
- Asked about the relieving factors
- Asked about any vomiting
- Asked about fever
- Asked about urinary problems
- Asked about bowel problems
- Asked about my last defecation (constipation).

Past History

- Asked about similar episodes in the past
- Asked about history of allergies
- Asked about past medical problems (high blood pressure, diabetes, acid peptic diseases, kidney stones etc..)
- Enquired about previous hospitalizations (surgery)
- Asked about family health.
- Asked about appetite and changes in weight
- Asked about smoking
- Asked about alcohol
- Asked about sexual history
- Asked about medications
- Asked about occupation and stresses in life

Examination

- Examinee washed hands
- Auscultated abdomen prior to palpation
- Palpated abdomen superficially

- Palpated abdomen deeply
- Checked rebound tenderness
- Looked for CVA tenderness
- Percussed for liver span
- Performed Psoas sign and Obturator sign
- Examined without gown not through the gown

Counseling

- Explained the physical findings and diagnosis
- Explained further work up (Blood tests, ultrasound, abdomen x ray)
- Explained the importance of lifestyle modifications by quitting smoking, alcohol.

Communication Skills

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact.
- Asked few open ended questions
- Asked non leading questions
- Asked one question at a time
- Listened to what ever I said with out interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances
- Asked whether I have any concerns/questions.

D.D for this Case

- Appendicitis
- Meckel's diverticulitis
- Perforated Peptic Ulcer
- Intestinal Obstruction
- Pancreatitis
- Urolithiasis

Investigations

- CBC with Differential Count

- Abdomen X-Ray
- Ultrasound Abdomen
- Pancreatic Enzymes
- Upper G.I Endoscopy

55-year-old male with bilateral leg pain

Vitals:

Pulse:	78/min
Temp:	98.0 F (36.7 C)
RR:	16/min
BP:	140/80 mmHg

Make a mental check list of DD for bilateral leg pain:

1. Thromboangiitis obliterans
2. Atherosclerotic vascular disease
3. Lumbar spinal stenosis
4. Diabetic polyneuropathy
5. Radiculopathy due to spinal disease
6. Medications, such as statins
7. Trauma
8. Deep vein thrombosis (rarely bilateral)

Unilateral pain:

1. Cellulites/myofascitis
2. Deep vein thrombosis
1. Rupture of Bakers cyst
2. Osteomyelitis
3. Bleeding into the leg (if the patient is on warfarin/coumadin)
4. Radiculopathy
5. Pathological fracture of the bone

SP's Notes

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Mr. David, age: 50 years
2. Have pain in both legs for past two months
3. Started insidiously, progressively increasing
4. 5-6/10 in severity
5. Mainly over the calf muscles
6. It is a type of throbbing pain
7. No radiation
8. Aggravating factors - walking, running, prolonged standing
9. Alleviating factors - rest and sitting
10. No rest pain, no fever, no trauma, no swelling, no back pain, no weakness
11. No sensory changes such as tingling or numbness in legs
12. No similar problems in the past
13. No sexual problems - sexually active with wife
14. Medical problems - have diabetes for past three years, but diet controlled, no high blood pressure; also have high cholesterol and takes simvastatin
15. No recent hospitalization; no prolonged bed rest
16. Father died because of stroke at 65; no family history of blood clots
17. Occupation - Working as a postal worker and having hard time at the end of the day
18. Smoking - two packs per day for 20 years
19. Alcohol - Occasionally
20. No allergies

case20 checklist

HPI:

- Asked about the location of pain (Where exactly is your pain? Do you have pain in one or both legs?)
- Asked about the onset of pain
- Asked about whether it is a continuous or intermittent pain (Is the pain worse at any particular time of day, like in the morning or at night?)
- Asked about intensity of pain
- Asked about the quality of pain
- Asked about the progression of pain
- Asked about any radiation of pain
- Asked about the aggravating factors (What makes the pain feel worse? For example, does exercise or long periods of standing worsen your pain?)
- Asked about the relieving factors (Is there anything that makes your pain feel better, like elevating your legs?)
- Asked about rest pain (peripheral vascular disease)
- Asked about swelling of the leg (deep vein thrombosis)
- Asked about sensory changes such as numbness, and paresthesia (Do you have any other symptoms, like numbness or tingling?)
- Asked about any weakness of legs (Any weakness?)
- Asked about any history of back pain (spinal stenosis) (Any back pain?)
- Asked about fever (deep vein thrombosis, cellulitis)
- Asked about trauma to legs
- Asked about recent surgery or prolonged immobilization (deep vein thrombosis)
- Asked about impotence (aortic occlusion)

PMH:

- Asked about similar episodes in the past
- Asked about past medical problems (high blood pressure, diabetes, high

cholesterol, disc prolapse)

SH:

- Asked about occupation and work impairment because of leg pain
- Asked about smoking
- Asked about alcohol

FH:

- Asked about family history of blood clots

All:

- Asked about history of allergies

Meds:

- Asked about my current medications

Examination:

- Examinee washed hands
- Examined calf tenderness
- Elicited Homan's sign
- Checked pulses in both legs and arms
- Listened for bruit at the distal aorta, iliac, or femoral arteries
- Checked sensation in both legs
- Checked reflexes in both legs
- Checked for vibration sense in both legs
- Examined without gown not through the gown

Counseling:

- Explained the physical findings and differential diagnosis
- Explained further workup (blood tests)
- Explained the importance of lifestyle modifications by quitting smoking and importance of regular exercise

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact

- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to what ever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this case:

- Thromboangiitis obliterans
- Atherosclerotic vascular disease
- Drug induced (statins)
- Diabetic polyneuropathy

Investigations:

- Creatinine kinase (CK) – For statin-induced myopathy
- Blood sugar and HbA1C
- Lipid profile
- Doppler arterial of lower extremities
- Duplex venous ultrasound of lower limbs, as needed, for deep vein thrombosis
- CBC, as needed, for infection
- MRI spine, as needed, for lumbar spinal stenosis

Note: For unilateral leg pain, also ask about any other joint problems (rheumatoid arthritis - ruptured Bakers cyst)

case21 Scenario

40-year-old male with vomiting of blood

Vitals:

PR: 88/min

Temp: 98.0 F (36.7 C)

RR: 20/min

BP: 110/80 mmHg

Make a mental checklist of DD for hematemesis:

1. Peptic ulcer decease
2. Gastric erosions
3. Esophageal varices
4. Mallory-Weiss tear
5. Esophagitis
6. Duodenitis
7. Malignancy (esophageal and gastric)

case21 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. 40-year-old, Mr. Ross
2. Had two episodes of vomitings for the last two hours
3. You take one baby aspirin daily for prevention of heart attack
4. Vomit contains one tablespoon of blood each time
5. Have abdominal pain of 4-5 in severity, no radiation, and nauseating feeling since yesterday
6. Your stools are black for the past month
7. Have had heart burn for the last two years, usually relieved by antacids
8. Appetite and weight are normal
9. No similar problems in the past
10. Never hospitalized

11. Working as a mail man (postal worker)
12. Smoking one pack per day for the past 25 years
13. Drinks four to five beers every day for the past 25 years
14. No family history of bleeding problems. Father died at the age of 60 with heart attack.
15. No allergies
16. Except aspirin, for past five days for headache, no other medications

case21 checklist

HPI:

1. Asked about the onset of vomiting
2. Asked about the frequency of vomiting
3. Asked about any blood in vomiting
4. Asked whether it was a frank blood or coffee ground vomiting
5. Asked about the quantity of blood
6. Asked about any abdominal pain associated with the vomiting
7. Asked about prior history of abdominal pain (or heartburn), especially in relation to food
8. Asked specifically about melena (black stools)
9. Asked about recent change in appetite and weight loss

PMH:

1. Asked about similar episodes in the past
1. Asked about other medical problems (peptic ulcer disease, reflux disease, liver problems)
2. Enquired about previous hospitalizations and surgeries

SH:

1. Asked about occupation
2. Asked about any alcohol intake, in detail (if necessary, CAGE questions)
3. Asked about smoking

FH:

1. Asked about family history of bleeding problems

All:

1. Asked about history of allergies

Meds:

1. Asked about my medications (particularly, aspirin and over-the-counter pain medications)

Examination:

1. Examinee washed hands
2. Informed me
3. Examined oropharynx
4. Auscultated abdomen prior to palpation
5. Palpated abdomen superficially
6. Palpated abdomen deeply
7. Checked for rigidity and rebound
8. Percussed for liver span
9. Examined without gown, not through the gown

Counseling:

1. Explained the physical findings and differential diagnosis
2. Explained further workup (blood tests, endoscopy)
3. Explained the importance of lifestyle modifications by quitting smoking, alcohol

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to what ever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques

- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D for this Case:

1. Peptic ulcer decease
2. Gastric erosions
3. Esophagitis
4. Duodenitis
5. Esophageal varices

Investigations:

1. Postural BP and HR measurement
2. CBC with differential count
3. PT/INR (coagulation studies)
4. BUN, serum creatinine, K, Na, CL, and Hco3
5. Upper GI endoscopy
6. Liver function tests (albumin, AST, ALT, alkaline phosphatase, total and direct bilirubin)

case22 Scenario 

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55 Yr. O/M Complaining of Chest Pain

Vitals

- Pulse--78/min
- Temp--98.7
- R.Rate--20/min
- B.P--130/80 mm of Hg.

Make a mental check list for Chestpain

- Myocardial Infarction
- Unstable Angina
- Pulmonary Embolism
- Costochondritis
- Pleuritis
- Pericarditis
- Aortic Dissection

- G.E.R.D
- Esophageal perforation

case22 SP

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mr. Adam, age: 55yrs
- Have chest pain since 2 hrs
- Started suddenly, progressively increasing
- 8-9/10 in severity
- Right behind the sternum
- Its a type of tightness and squeezing in quality.
- No radiation
- Walking and moving around makes it worse
- No alleviating factors
- Associated with 1 episode of vomiting and sweating
- Have mild shortness of breath
- No Fever
- No Cough
- No similar problems in the past,
- No Allergies.
- Had high blood pressure for 20 yrs taking Atenolol 50 mg.
- Had diabetes since 5 yrs but its under control
- Never hospitalized
- No Urinary or bowel problems
- Families' health: father died because of heart attack
- Mother had stroke

- Smoking – 1 pack per day for 30yrs
- Alcohol - 1 glass of wine / day since 15 yrs
- Occupation-- Working as a librarian
- Appetite and weight is normal
- Diet -- eats lot of junk and fatty food.
- Tested for cholesterol 1yr ago and it was 280.
- No illicit drug intake [cocaine]

case22 checklist

History Taking [General Proforma]

- Asked about the location of pain
- Asked about the intensity of pain
- Asked about the quality of pain
- Asked about the origin and duration of pain
- Asked about the progression of pain
- Asked about any radiation of pain
- Asked about the aggravating factors.
- Asked about the relieving factors
- Asked about any vomiting and sweating
- Asked about fever
- Asked about cough
- Asked about shortness of breath
- Asked about palpitations
- Asked about syncope and dizziness.

Past History

- Asked about similar episodes in the past
- Asked about history of allergies
- Asked about past medical problems [high blood pressure, other heart problems, diabetes, heart burn/reflux]
- Enquired about previous hospitalizations
- Asked about urinary and bowel problems
- Asked about family health.
- Asked about appetite and changes in weight

- Asked about smoking
- Asked about alcohol
- Asked about medications and compliance
- Asked about occupation and stresses in life
- Asked about cholesterol level if I known

Examination

- Examinee washed hands
- Performed eye examination with ophthalmoscope
- Looked for J.V.D
- Palpated for P.M.I
- Listened my heart
- Auscultated all over the lungs
- Examined without gown not through the gown .

Counseling

- Explained the physical findings and diagnosis
- Explained further work up [Blood tests, chest – X Ray, ECG, cardiac enzymes, angiogram]
- Explained the importance of lifestyle modifications by quitting smoking , alcohol and exercise program

Communication Skills

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact.
- Asked few open ended questions
- Asked non leading questions
- Asked one question at a time
- Listened to what ever I said with out interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances
- Asked whether I have any concerns/ questions.

D.D for this Case

- Myocardial Infarction
- Unstable Angina
- Pulmonary Embolism
- Aortic Dissection
- G.E.R.D

Investigations

- CBC with differential count
- Cardiac Enzymes
- ECG and Chest X Ray
- Echo cardiogram
- Coronary Angiogram and Lipid profile

70 Yr. O/M complaining of Frequent Falls

Vitals

- Pulse--78/min
- Temp--98.7
- R.Rate--20/min
- B.P--130/80 mm of Hg.

Make a mental checklist of differential diagnosis for falls

- Cerebellar disease [Alcoholic/Tumor]
- Parkinson's disease [Idiopathic/drug induced]
- Diabetic neuropathy [Sensory ataxia]
- Brain tumors
- Hyperthyroidism
- Fractured hip
- Seizure
- Vertigo

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mr. Adam, age: 70yrs
- Have been falling frequently for past two months.
- Started like twice a week to now twice a day increasing,
- Have problem in maintaining balance when you try to stand
- No major injury until now, but are concerned if you will have any fracture
- You get once in a while some palpitations too and then once you loose your consciousness
- Have problem in holding things your hands keep on shaking and this increases especially when you try to reach for an object.
- Your friend says that your speech has changed and you have noticed that too.
- You have lost a lot of weight in last two months,
- You have headache on and off. But it is mostly in the mornings.
- You are not sexually active, your wife passed away five years back
- Your son does not live in the same city
- You do not have any problem with calculation and memory, but have difficulty in reading.
- Have diabetes since 10 yrs but under strict control.
- No difficulty in urination, bowel and sleep
- No smoking,
- Alcohol--2 beers a day for 3o yrs
- You have been taking phencyclidine for past 15 yr. and have stopped just 5 months back.
- Retired from job.
- Do not have any body to talk to.

History Taking [General Proforma]

This case is going to have a big check list. Try to do as much as you can. Obviously you will forget to do many things in the exam, but never panic, everyone has the same problem. If you practice this much at this stage it will be useful during the exam even if you miss some things.

- Asked about the onset and frequency of fall
- Asked about any injury associated with fall
- Asked about loss of consciousness [Did you lose consciousness before or after your fall?]
- Asked about any difficulty in initiating movements, stopping movements [Did you notice any difference in the way you walk?]
- Asked about progression of the problem
- Asked about any tremors [Do you get tremors, I mean any shaking of your hands..?]
- Asked about headache
- Asked about any vomiting
- Asked about fever
- Asked about any palpitations and syncope
- Asked about speech problem
- Asked about problem with memory
- Asked about problem with calculation
- Asked about urinary problems
- Asked about bowel problems
- Asked about the living condition and supporting systems [Could you please describe about your living conditions briefly for me? Do you have any one to help You?]
- Asked about thyroid problems [temperature intolerance, voice change, hair loss]

Past History

- Asked about similar episodes in the past
- Asked about history of allergies

- Asked about past medical problems [high blood pressure, stroke, diabetes, thyroid]
- Inquired about previous hospitalizations [surgery]
- Asked about family health. [Has any one in your family had Parkinson's disease or stroke?.]
- Asked about appetite and changes in weight
- Asked about smoking
- Asked about alcohol
- Asked about sexual history
- Asked about medications
- Asked about drugs intake
- Asked about occupation

Examination

- Examinee washed hands
- Examined eyes
- Examined neck
- Examined heart and lungs
- Examined Mini -mental status
- Examined touch, pain and temperature sensations in legs and hands
- Tested muscle power in limbs
- Tested for rigidity
- Asked me to get up and walk and turn around and sit again
- Did finger nose test
- Did alternating movements test
- Did Romberg's test
- Checked jerks in limbs including planters

Counseling

- Explained the physical findings and diagnosis
- Explained further work up [Blood tests, blood sugar, MRI]

Communication Skills

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact.
- Asked few open ended questions

- Asked non leading questions
- Asked one question at a time
- Listened to what ever I said with out interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances
- Asked whether I have any concerns/ questions.

D.D for this Case

- Cerebellar disease [Alcoholic/Tumor]
    - Parkinson's disease (idiopathic/drug induced)
    - Diabetic neuropathy [Sensory ataxia]
    - Brain tumors
    - Hyperthyroidism

Investigations

- CBC with differential
- CT or MRI [posterior Fossa]
- Serum electrolytes
- ECG
- S. Phencyclidine levels
- TSH, T3, and T4.

35 Yr. O/M Complaining of Cough and Chest Pain

Vitals

- Pulse--94/min
- Temp --101.7
- R.Rate --24/min
- B.P--130/80 mm of Hg.

Make a mental check list for Cough and Chestpain

- Pneumonia
- Pleuritic pain
- Pleural effusion
- Pulmonary edema
- Tuberculosis
- Pulmonary embolism
- Ca. Bronchus
- Infective endocarditis
- GERD

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

1. You are Mr. Littman, age: 32yrs
2. Have chest pain since 2 days and cough from 2 days
3. Started in the morning with malaise
4. 5-6/10 in severity
5. On the left side of chest
6. It's a type of sharp, shooting, electric pain.
7. All over your left chest.
8. Moving around, deep breath makes it worse & relieved by expiration
9. Fever with chills twice fever remains between the episodes of the chills
10. Cough is present with expectoration. It is 2 – 5 teaspoon in amount, yellow in color, fowl smelling and there is no blood in the expectoration/sputum
11. Sweating present: Mild shortness of breath with exertion present (pt keeps on asking…will I survive, is this Pneumonia, Can I attend volunteer services, what will happen to my other commitments)
12. No bowel problems
13. Allergies to Penicillin and aspirin.
14. Once hospitalized for evaluation of angina, has toothache since 15 days and it was removed 7 days back.
15. Have single sexual partner
16. Families' health – all are well. A friend suffered from pneumonia few days back in office.
17. Smoking –yes, 1pack for 20 yr.
18. Alcohol- two shots every weekend when he goes for playing pool with his friends
19. Occupation: Working as a Senior Investment Advisor with Morgan Stanley
20. Appetite reduced and wt is decreased
21. No illicit drug intake

case24 checklist

History Taking [General Performa]

1. Asked about the location of pain
2. Asked about the intensity of pain
3. Asked about the quality of pain
4. Asked about the origin and duration of pain
5. Asked about the progression of pain
6. Asked about any radiation of pain
7. Asked about the aggravating factors.
8. Asked about the relieving factors
9. Asked about any vomiting
10. Asked about fever
11. Asked about cough
12. Asked about any expectoration
13. Asked quantity of expectoration, color, smell, and increase or decrease with change with position
14. Asked about shortness of breath
15. Asked about hemoptysis

Past History

1. Asked about similar episodes in the past
2. Asked about history of allergies
3. Asked about past medical problems (high blood pressure, diabetes, lung problems)
4. Inquired about previous hospitalizations (surgery)
5. Asked about last PPD
6. Asked about family health.
7. Asked about appetite and changes in weight
8. Asked about smoking
9. Asked about alcohol
10. Asked about sexual history

11. Asked about medications
12. Asked about occupation

Examination

1. Examinee washed hands
2. Inspection of neck, accessory muscles of respiration and JVD
3. Inspection of chest and PMI
4. Auscultated chest anteriorly and posteriorly in sitting position and bending forward position.
5. Asked me to say 99 repeatedly (Palpated for tactile vocal fremitus) (S.P will say 99 loudly/slowly when it comes to lower part of the lung to mimic consolidation or plural effusion respectively)
6. Percussed on the chest.
7. Palpated abdomen for splenomegaly and hepatomegaly
8. Auscultated at the base of lungs for rales
9. Examined without gown not through the gown

Counseling

1. Explained the physical findings and diagnoses
2. Explained further work up [Blood tests, urinalysis, Chest x ray, EKG]
3. Explained complications of disease, differential diagnosis (Pneumonia, Pleuritis, Pleural Effusion, Ca. Bronchus)
4. Explained reason to quit cigarette smoking and alcohol
5. Explained the importance of safe sexual practices and use of condoms.

Communication Skills

1. Knocked before entering the room
2. Introduced himself and greeted warmly
3. Used my name to address me
4. Paid attention to what I said and maintained good eye contact.
5. Asked few open ended questions
6. Asked non leading questions
7. Asked one question at a time

8. Listened to what ever I said with out interrupting me in between
9. Used lay man's language
10. Used appropriate transition sentences
11. Used appropriate draping techniques
12. Summarized the history and explained physical findings
13. Expressed empathy, made appropriate reassurances
14. Asked whether I have any concerns/ questions.

D.D for this Case

1. Pneumonia
2. Pleuritic pain
3. Pleural effusion
4. Infective Pericarditis/Endocarditis
5. Ca. Bronchus

Investigations

1. CBC with differential count and ESR
2. Sputum Gram stain, C/S, Cytology
3. EKG
4. Chest X-Ray
5. Blood Culture

60-year-old male complaining of lower abdominal pain

Vitals:

PR: 98/min

BP: 130/85 mmHg

T: 101 F (38.3 C)

RR: 22/min

Make a mental checklist of Differential Diagnosis:

1. Diverticulitis
2. Renal colic
3. Appendicitis
4. Ischemic colitis
5. Infectious colitis
6. Leaking aneurysm
7. Intestinal obstruction from strangulated or incarcerated hernia

*** If the doctor asks you anything other than these, just say 'no, ' or say things that are normal in daily routine life.**

1. You are Mr. David, age: 65 years
1. Have abdominal pain for the past 24 hours; it started slowly, progressively increasing; now it is 5-6/10 in severity. The pain is mainly over the left side of your lower abdomen.
2. It is a type of crampy pain
3. No radiation
4. No aggravating factors
5. No alleviating factors
6. Has feeling of nausea and had vomited once, but no blood in the vomit
7. Had diarrhea 2-3 times yesterday with one episode of bleeding, but no prior black stools. The diarrhea and vomiting started after the abdominal pain.
8. No urinary problems
9. Have slight fever since yesterday, but no chills
10. Went outside for dinner with the family yesterday, but none of them are sick
11. No recent travel
12. Appetite is decreased
13. Lost 10 pounds of weight in last 3 months
14. Never had this type of pain before
15. Ten years ago, you had a kidney stone, but that pain is not this severe. That stone passed spontaneously.
16. You were hospitalized only once for that kidney stone. Never had any surgeries.
17. Smoking – No
18. Alcohol - 1 beer daily for past 15 years
19. Family history – Father died from colon cancer when he was age 63
20. You take only hydrochlorothiazide for high blood pressure. No other

medications and no recent antibiotic use.

21. No known drug allergies

case25 checklist

HPI:

- Asked about the location of pain
- Asked about the intensity of pain
- Asked about the quality of pain
- Asked about the onset and duration of pain
- Asked about the progression of pain
- Asked about any radiation of pain
- Asked about the aggravating factors
- Asked about the relieving factors
- Asked about nausea and vomiting
- Asked about fever and chills
- Asked about bowel problems (constipation and diarrhea)
- Asked about any blood in the stool or black stools
- Asked about urinary symptoms
- Asked about recent travel and contaminated food ingestion
- Asked about appetite and changes in weight

PMH:

- Asked about similar episodes in the past
- Asked about other medical problems (kidney stones, diverticulosis, inflammatory bowel disease, heart disease, atrial fibrillation)
- Asked about any prior surgeries and recent hospitalizations (appendix removal)

SH:

- Asked about smoking
- Asked about alcohol intake

FH:

- Asked about the family history of cancer

Meds:

1. Asked about current medications
2. Asked about the recent antibiotic use (for possible Clostridium difficile colitis)

All:

1. Asked about history of drug allergies

Examination:

1. Examinee washed hands
2. Auscultated abdomen
3. Palpated abdomen superficially
4. Palpated abdomen deeply
5. Checked rebound tenderness
6. Looked for costovertebral angle tenderness
7. Quickly auscultated the heart
8. Examined without gown, not through the gown

Counseling:

1. Explained the physical findings and differential diagnosis
2. Asked me to perform rectal examination
3. Explained further workup (blood tests, EKG, abdomen x-ray, CT scan)

Communication Skills:

1. Knocked before entering the room
2. Introduced himself and greeted warmly
3. Used my name to address me
4. Paid attention to what I said and maintained good eye contact
5. Asked few open-ended questions
6. Asked non-leading questions
7. Asked one question at a time
8. Listened to whatever I said without interrupting me
9. Used lay man's language
10. Used appropriate transition sentences

11. Used appropriate draping techniques
12. Summarized the history and explained physical findings
13. Expressed empathy, gave appropriate reassurances
14. Asked whether I have any concerns/questions

D.D for this case:

1. Diverticulitis
2. Renal colic
3. Intestinal obstruction
4. Infectious colitis
5. Ischemic colitis

Investigations:

1. Rectal examination with heme check stools; genital examination
2. CBC with differential count
3. Basic metabolic panel (Na, K, BUN, Cr, Co2, Cl, Ca)
4. Urinalysis
5. EKG
6. Abdomen x-ray
7. CT scan of the abdomen and pelvis

case26 Scenario

35-year-old male complains of fatigue

Vitals:

- PR: 82/min
- BP: 120/80 mmHg
- RR: 16/min
- Temp: 96.8 F (36.0 C)

Mental Checklist of DD:

- Depression
- Anemia
- Hypo or Hyperthyroidism
- HIV or AIDS
- Malingering
- Hypochondriasis
- Post Traumatic Stress Disorder
- Chronic fatigue syndrome

case26 SP

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Edward, age 35 years
- Feeling very weak and low for past 2 months
- Getting tired very soon
- Not able to sleep properly
- Having nightmares almost every night
- Had a traumatic event of getting robbed 2 months back
- No shortness of breath
- Feeling anxious all the time
- No associated palpitations or sweating or tremor of hands

- Restricted my daily activities to minimal
- Not able to concentrate on work
- Feeling emotionally distant and lonely
- No change in appetite or weight
- No fever
- Did not notice any swelling in neck
- Has been having constipation for the past 3-4 months but no black stools; bladder habits are normal
- Smokes 1 pack/day, for past 10 years; Not an alcoholic
- Occupation is florist
- No stress at home or at work
- Not using any medications
- Never hospitalized
- Single sexual partner
- No illicit drug use
- All family members are healthy

case26 checklist

History:

- Asked about onset of weakness
- Asked if I was feeling tired
- Asked if I am able to sleep properly
- Asked if I am having difficulty falling asleep or staying asleep
- Asked about nightmares
- Asked if I had any traumatic event recently
- Asked about feeling of guilt
- Asked about suicidal intentions
- Asked if I was feeling lonely
- Asked if I have shortness of breath
- Asked about anxiety
- Asked if it is associated with any symptoms, like palpitations, dizziness, sweating, or tremors
- Asked about any recent changes in appetite or weight
- Asked about bowel and bladder habits

- Asked if I noticed any swelling in neck
- Asked about my occupation
- Asked about stress at work or home
- Asked about any medications I am using
- Asked about sexual practices
- Asked about illicit drug use
- Asked about smoking and alcohol intake

Past History:

- Asked about similar episodes in the past
- Asked about previous hospitalizations
- Asked about past medical problems (hypertension, diabetes mellitus, kidney or liver problems)
- Asked about family history of similar problems

Examination:

- Informed me
- Washed hands
- Examined mucous membranes for pallor
- Palpated my neck for mass or swelling
- Checked my memory, orientation, and judgment

Counseling:

- Explained physical findings and probable diagnosis
- Explained further workup
- Offered to talk to my family
- Offered to help and support while getting treated
- Explained the importance of quitting smoking in long term and offered help

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly

- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me in between
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, made appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Post Traumatic Stress Disorder
- Depression
- Hypothyroidism
- Occult medical disease

Investigation:

- CBC with differential
- ESR
- Thyroid function tests
- Basic metabolic panel (Na, K, BUN, Cr, Co2, Cl)

case27 Scenario 

65-year-old female complaining of loss of hearing

Vitals:

PR: 80/min

BP: 130/86 mmHg

T: 98.0 F (36.7 C)

RR: 16/min

Make a mental check list of DD for loss of hearing:

Conducting hearing loss:

1. Cerumen impaction
2. Otitis media with effusion
3. Tympanic membrane perforation
4. Otosclerosis
5. Foreign body in ear canal
6. Cholesteatoma
7. Tympanosclerosis
8. Tumor of the ear canal or middle ear

Sensorineural hearing loss:

- Presbycusis (hearing loss with aging)
- Ototoxicity
- Noise-induced loss
- Meniere's disease
- Diabetes
- Acoustic neuroma

case27 SP

**If the doctor asks you anything other than these, just say 'no, ' or say things that are normal in daily routine life.*

1. You are a 65-year-old woman
1. You have noticed decreased hearing in your left ear
1. Noticed it for the past 3 months
1. Progressively increasing
1. Especially prominent when somebody with a shrill voice speaks to you
1. Nothing makes it better or worse

1. You have not had any earache, but you have an ear infection history 10 years back, which resolved with antibiotics
1. No pus or discharge from the ear
1. You have no sensation of ringing in your ear
1. You don't feel that the room is spinning around you
1. You don't have any dizziness or feeling of imbalance
1. You have been working in an industry where iron and steel is recycled and frequently expose you to loud noises
1. There has been no weakness with any of your facial muscles
1. You don't have any other neurological problems, like loss of sensation, numbness, tingling any where in the body
1. You take hydrochlorothiazide for high blood pressure. You were admitted in the hospital for severe urinary tract infections, for which you were treated with antibiotics. You don't know the names.
1. No family history of hearing loss
1. Never had any syphilis, or other medical problems except high blood pressure and two episodes of urinary tract infection
1. You are feeling okay with your life, but are frustrated with the hearing problem

case27 checklist

HPI:

1. Asked about the affected side of hearing loss (right, left, bilateral)
2. Asked about the onset (congenital, early, late)
3. Asked if it was progressive (stable, progressive, fluctuating)
4. Asked about the subjective severity of hearing loss (mild, moderate, severe, profound)
5. Asked about the possible inciting events
6. Asked about aggravating factors
7. Asked about alleviating factors
8. Asked about associated problems (earache, tinnitus, vertigo, aural fullness, previous or current draining from ear)
9. Asked about any occupational exposure to sounds
10. Asked about the trauma to ear

11. Asked about the social impact that it has had
12. Inquired if I had any other problems

PMH:

1. Asked about any similar episodes in the past
2. Asked if I had any other significant medical conditions (History of meningitis, syphilis, Lyme disease, diabetes)

SH:

1. Asked about the occupation (recent air travel or underwater diving)

FH:

1. Asked about the family history of hearing loss

All:

1. Asked about any known drug allergies

Meds:

1. Asked if I was taking any medications (particularly, diuretics and antibiotics)

Examination:

1. Washed hands prior to examining
2. Used appropriate draping technique
3. Checked for vision
4. Checked for eye movements
5. Checked for jaw muscles and sensations on the face
6. Asked me to show my teeth
7. Asked me to puff out my cheeks
8. Asked me close my eyes, and then closed one ear while checking the other ear for hearing
9. Did an otoscopy by pulling back the pinna
10. Performed the Rinne test (AC>BC) in both ears
11. Performed the Weber test (localized to the right ear)
12. Asked me to swallow
13. Asked me to put my tongue out and move it from side to side

14. Asked me to shrug
15. Checked position sense
16. Did most of the neurological exam

Counseling:

1. Explained the physical findings and differential diagnosis
2. Explained the workup (audiometry)

Communication Skills:

1. Knocked before entering the room
2. Introduced himself and greeted warmly
3. Used my name to address me
4. Paid attention to what I said and maintained good eye contact
5. Asked few open-ended questions
6. Asked non-leading questions
7. Asked one question at a time
8. Listened to whatever I said without interrupting me
9. Used lay man's language
10. Used appropriate transition sentences
11. Used appropriate draping techniques
12. Summarized the history and explained physical findings
13. Expressed empathy, gave appropriate reassurances
14. Asked whether I have any concerns/questions

D.D for this case:

1. Presbycusis
2. Eardrum damage from occupational exposure
3. Cerumen impaction
4. Drug induced

Investigations:

1. CBC and ESR
2. Serum electrolytes and blood sugar
3. Audiometry
4. Fluorescent treponemal antibody, absorbed (as needed)
5. MRI of the brain (as needed)

6. Lyme titers (as needed)

case28 Scenario

A 53-year-old male with right knee pain and swelling

Vitals:

PR: 80/min, regular

BP: 130/60 mmHg

RR: 18/min

T: 101.0 F (38.3 C)

Mental Checklist of DD:

- Osteoarthritis
- Septic arthritis
- Pseudogout and gout
- Reactive arthritis
- Traumatic knee injury
- Lyme disease
- Monoarticular rheumatoid arthritis
- Psoriatic arthritis

case28 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

- You are Mr. Scott, age 53 years
- Actually, you have pain in both the right and left knees for the past year, and you are thinking that is due to your heavy weight; but, for the past 2 days, you are having severe right knee pain. You are having difficulty in walking because of pain.
- The pain is all around the right knee joint, constant pain, throbbing in nature, no radiation to anywhere, and it is 7 out of 10 in severity. You

tried ibuprofen, but it did not relieve your pain

- There are no aggravating and relieving factors for pain, and you do not know what might have precipitated it
- You have 10-15 minutes of morning stiffness in your joints everyday
- There is no history of trauma to your knee joint
- You feel warm, but no fever, chills, nausea, or vomitings. You did not take your temperature.
- There is no history of febrile (flu-like) illness or diarrhea in the recent months
- You do not have pain or swelling in other joints
- There is no history of rash anywhere in your body (even in the past)
- You do not have any other complaints
- You never traveled to any where for the past 5-6 years
- No history of tick bites or insect bites
- Three years back, you had pain and swelling in the right and left wrists and fingers and subsided with ibuprofen
- You do not have any problems with your bowel movements or urination
- You are a retired librarian
- Not sexually active for the last couple of years, because you do not feel like having sex
- No illicit drug use
- Family history - mother has a history of pseudogout and father is hypertensive
- Using Tylenol (acetaminophen) occasionally for knee pain for the past year
- You have no known drug allergies

case28 checklist

History:

- Asked about the onset of pain
- Asked about progression
- Asked about the severity of pain

- Asked about location
- Asked about quality
- Asked about radiation
- Asked about the aggravating and relieving factors
- Asked about associated symptoms, like fever, nausea, vomiting
- Asked about history of trauma to the joint
- Asked about history of morning stiffness
- Asked about history of travel (for Lyme disease endemic areas)
- Asked about any history of tick bites
- Asked about any rash anywhere in the body
- Asked about any pain and swelling in the other joints
- Asked about any recent history of febrile illness
- Asked about any eye symptoms
- Asked about bowel and bladder habits

Past Medical History:

- Asked about similar episodes in the past or joint problems
- Asked about past medical problems (inflammatory bowel disease, gout, pseudogout, rheumatoid arthritis, or osteoarthritis)

SH:

- Asked about occupation
- Asked about illicit drug use
- Asked about sexual practices

FH:

- Asked about family history of joint diseases

Meds:

- Asked about any medications I am using

Allergies:

- Asked about any drug allergies

Examination:

- Informed me
- Washed hands
- Draped appropriately
- Checked my knee for full range of motion
- Checked my knee for an effusion by ballottement or bulge method
- Checked all other joints for swelling and redness

- Auscultated heart
- Examined my eyes
- Examined my skin for rashes or painful nodules

Counseling:

- Explained the physical findings and possible diagnosis
- Explained further workup (CBC with differential, ESR, joint aspiration, x-ray)
- Offered ongoing support

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Osteoarthritis
- Septic arthritis
- Pseudogout
- Monoarticular rheumatoid arthritis
- Gout

Investigations:

- CBC with differential
- PT/INR before aspiration
- Joint aspiration
- Knee x-ray

- ESR, ANA, Rheumatic Factor

Additional:

- MRI of joint for history of trauma
- Lyme titers for history of tick bite and travel to Lyme endemic areas (New England, etc.)

Important points:

You may get a case of trauma to the knee also. In such a scenario, please ask the following questions and do the following tests along with the above checklist:

- Ask what was he (patient) doing at the time the pain began.
- Ask are there any noises heard at the time of injury (Popping sound indicates anterior cruciate ligament injury).
- Ask whether the knee was buckling or unstable.
- Ask about locking and unlocking of joint (for meniscal injury).
- Perform Lachman's maneuver or Drawers test for cruciate ligament injury.
- Perform McMurray's maneuver.
- In the counseling, explain that he needs immediate orthopedics consultation for possible meniscal or ligamental injury.

case29 Scenario

A 50-year-old man with blurred vision

Vitals:

BP: 150/90 mmHg

Temp: 98.0 F (36.7 C)

Pulse: 70/min

RR: 16/min

Make a mental checklist of DD for blurry vision:

- Diabetes mellitus
- Cataract
- Hypertensive retinopathy
- Glaucoma
- Macular degeneration
- Brain lesions

- Hyperviscosity syndromes (polycythemia)
- Illegal drugs
- Temporal arteritis (usually starts unilateral)
- Trauma or infections to the eye (if unilateral)

case29 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are a 50-year-old man
2. You have come to the doctor due to the chief problem of blurred vision in both eyes
3. You have not seen a doctor for the past 10 years
4. You have had blurred vision since approximately 2 months, on and off
5. You do not have any eye discharge, halos around light, and you don't have any eye pain
6. You do not have nausea, vomiting, headache, weakness in the arms and legs
7. You do not have any history of seizures, loss of consciousness, complete loss of vision, eye problems
8. You have been experiencing excessive thirst of late
9. You have been eating more than you usually do over the past few months
10. You have lost about 10 pounds over the past few months
11. Your mother has diabetes, and she uses pills for the problem
12. You do not know if you have any medical problems, because you have not seen any doctor for the past few years
13. You are a postal worker
14. You do not drink alcohol, except a couple of beers on weekends
15. You smoke 1 pack/day
16. You do not use any recreational drugs
17. You are sexually active with your wife only; no problem with sex

case29 checklist

HPI:

1. Asked about the onset of the complaints
2. Asked about the progression of the complaints
3. Asked about sudden transient complete loss of vision at any time
4. Asked about eye discharge
5. Asked about halos around the light
6. Asked about the pain in the eye
7. Asked about any headache
8. Asked about the nausea and vomiting
9. Asked about any weakness in the arms and legs
10. Asked about sensory changes in legs
11. Asked about excessive thirst
12. Asked about excessive food intake
13. Asked about excessive urination
14. Asked about loss of weight

PMH:

1. Asked about prior history of diabetes or high blood pressure

SH:

1. Asked about smoking
2. Asked about alcohol

FH:

1. Asked about family history of diabetes

All:

1. Asked about drug allergies

Meds:

1. Asked about my medications

Examination:

1. Informed me
2. Washed hands
3. Checked my eyes with an ophthalmoscope
4. Did a focused neurological exam with special emphasis on sensory examination of the extremities
5. Tested for vibration sensations on bony prominences proceeding from distal to the proximal
6. Listened to my carotid arteries
7. Did an abbreviated heart exam (PMI palpation, auscultation)
8. Felt for pulses in the lower limbs

- Examined without gown, not through the gown

Counseling:

1. Explained to me the possibility of being afflicted with diabetes
2. Explained the importance of weight reduction
3. Explained that diet would be a major part of my treatment regimen. Medications would be secondary.
4. Explained that regular follow-up would be necessary for my vision and other problems
5. Explained that I can monitor my own blood sugar
6. Motivated me towards a better lifestyle

Communication Skills:

1. Knocked before entering the room
2. Introduced himself and greeted warmly
3. Used my name to address me
4. Paid attention to what I said and maintained good eye contact
5. Asked few open-ended questions
6. Asked non-leading questions
7. Asked one question at a time
8. Listened to whatever I said without interrupting me in between
9. Used lay man's language
10. Used appropriate transition sentences
11. Used appropriate draping techniques
12. Summarized the history and explained physical findings
13. Expressed empathy, made appropriate reassurances

14. Asked whether I have any concerns/questions

D.D for this case:

1. Diabetic retinopathy
2. Hypertensive retinopathy
3. Cataracts
4. Glaucoma
5. Macular degeneration

Investigations:

1. CBC with differential count
2. Fasting blood glucose and HbA1C
3. Urinalysis for microscopic proteinuria
4. Lipid profile
5. Doppler of carotids

32-year-old Michelle with multiple bruises

Vitals:

PR: 90/min

BP: 120/80 mmHg

RR: 16/min

Temp: 99.4 F (37.4 C)

Mental Checklist of DD:

- Accident
- Physical assault
- Spousal abuse
- Bleeding disorders
- Collagen vascular disorders

***If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are a 30-year-old woman
2. You have a bruise on the right arm between your shoulder and your elbow
3. You are accompanied by your husband
4. When the doctor asks you how you sustained the injury, you tell him that, "My husband told me that I fell down the stairs."
5. On further questioning by the doctor, you say that you have been hit by your husband
6. You have been married for 7 years
7. Your husband is a truck driver
8. Your husband hits you whenever he has his rage episodes - usually once a week
9. You have 2 children, a boy (age 6) and a girl (age 5). He does not hit them. He loves them, but they are afraid to go near him when he has his rage episodes.
10. Your husband is an alcoholic, and he almost always has a bottle of bourbon by his side
11. Both your parents are living in the same town as you are and neither of them is aware of the abuse that you are subject to
12. You feel that your husband loves you
13. You love your husband, but you are always on the edge when he is around
14. You feel that it is very difficult for you to leave him
15. You have never reported the matter to any agency
16. You do not feel safe at home, especially when he is around
17. You have felt at least on two occasions that he might kill you
18. You do not have an emergency plan to leave home if the need arises
19. You do not wish the matter to be reported to the authorities
20. You have a satisfying sexual relationship with him, and you are

monogamous

21. You do not smoke, drink, or use recreational drugs
22. There is a shotgun at your house. You think your husband might use it.
23. When the doctor persuades you that you need not endure such a relationship in which you are always in mortal fear, you say that you are going to think about reporting it to the social welfare agencies
24. If you have been persuaded enough by the doctor, take his phone number and tell him that you are going to call him if the need arises.

case30 checklist

HPI:

- Doctor knocked before entering the room
- Asked how the injuries have occurred
- Asked me an open-ended question regarding the abuse
- Asked if this happens regularly
- Asked about how I felt about my husband
- Asked about how my husband felt towards me
- Asked about my feeling of safety at my home
- Asked if there were any weapons at my home
- Asked about my sexual relationships with my husband
- Asked if I had an emergency plan to leave the house if the need arises
- Asked about any other injuries that I had
- Asked if my family was aware that I was being abused
- Asked about my husband's alcoholism
- Asked about child abuse at the house
- Asked about his and my occupation/profession

PMH:

- Asked about other medical problems

SH:

- Asked about my smoking/alcohol/recreational drug use

FH:

- Asked about family history of bleeding disorders

Medications:

- Asked about use of any medication

Allergies:

- Asked about any known drug allergies

Examination:

- Informed me
- Washed hands
- Did not neglect the physical exam
- Asked me to touch the opposite shoulder
- Checked if I had any other injuries
- Checked my arm to see if it was broken

Closure:

- Informed me that I might have a broken upper arm
- Informed me that he was ordering an x-ray to rule out a fracture
- Gave me his office phone number and offered me ongoing support

Communication Skills:

- Greeted me warmly with my name
- Introduced himself by his name
- I felt comfortable while talking to him
- Made me feel at ease
- Established rapport with me
- Acknowledged my husband's presence and politely requested him to leave the room
- Was not abrasive when he confronted me with the fact that my injury did not look like being caused from a fall
- Acknowledged the fact that it is very difficult to leave an abusive husband
- Advised me to consider the option of reporting the matter to the welfare agencies
- Did not take it upon himself to report the matter to the authorities
- Explained to me that children should not be growing up in an environment where they are subject to terror

- Explained to me the importance of an emergency plan (packing some clothes, utilities, and money that would last me a week and leaving the suitcase in a friend's house)
- Informed me of the support groups that existed in the community

Diagnosis:

- Spousal abuse

Investigations:

- CBC and the others depending on the type of injury

case31 Scenario

A 20-year-old Elisa with burning urination

Vitals:

PR: 82/min

BP: 110/80 mmHg

RR: 16/min

Temp: 101.0 F (38.3 C)

Mental Checklist of DD:

1. Cystitis
2. Pyelonephritis
3. Urethritis
4. Vulvovaginitis
5. Pelvic inflammatory disease
6. Noninflammatory dysuria (trauma, irritant, allergy)

case31 SP

***If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Elisa, age 20 years
2. Having burning urination for the past 4 days
3. Associated with fever, around 101 F

4. Having chills and rigors
5. No nausea and vomiting
6. Noticed a tinge of blood in urine
7. Frequency of urination increased up to 10 times/day; you are also having frequent urge to go to bathroom
8. Having mild, dull constant pain in the suprapubic area
9. No back pain
10. Having some greenish vaginal discharge for couple of days, but no vaginal bleeding
11. You had a similar episode one year ago, and it was diagnosed as chlamydia infection of the cervix and was treated with doxycycline as an outpatient
12. No other medical problems
13. You recently changed your sexual partner; no pain during sexual intercourse
14. Using oral contraceptive pills for contraception; never used condom as contraception
15. Last menstrual period was 14 days ago
16. Not a smoker
17. Occasionally drinks a glass of wine
18. Not using any other medications
19. Occupation is a college student
20. No known drug allergies

case31 checklist

HPI:

- Asked about onset of dysuria
- Asked about frequency
- Asked about urgency
- Asked about hematuria
- Asked about suprapubic, abdominal, and back pain
- Asked about fever and chills
- Asked about nausea and vomiting

- Asked about vaginal discharge
- Asked about abnormal vaginal bleeding
- Asked about pain during intercourse
- Asked about last menstrual period
- Asked about sexual practices
- Asked about contraceptive methods

PMH:

- Asked about similar episodes in the past
- Asked about previous hospitalizations
- Asked about past medical problems (diabetes mellitus, sexually transmitted disease, pelvic inflammatory disease, and urinary tract infections)

SH:

- Asked about occupation
- Asked about smoking and alcohol intake

Meds:

- Asked about medications I am using

Allergies:

1. Asked about any known drug allergies

Examination:

- Informed me
- Washed hands
- Auscultated my abdomen
- Palpated my abdomen superficially
- Palpated my abdomen deep
- Palpated my back for costovertebral angle tendons
- Elicited suprapubic tenderness
- Examined without gown, not through the gown

Counseling:

- Explained physical findings and probable diagnosis
- Explained further workup
- Explained that I need pelvic examination

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Cystitis
- Pyelonephritis
- Urethritis
- Vulvovaginitis
- Pelvic inflammatory disease

Investigation:

- Pelvic examination
- CBC with differential
- Urinalysis
- Culture of urine

A 50-year-old male with difficulty swallowing

Vitals:

BP: 130/90 mmHg
PR: 85/min
Temp: 98 F (36.7 C)
RR: 16/min

Make a mental checklist of DD:

Oropharyngeal dysphagia:

- Neuromuscular (CVA, Parkinsonism, multiple sclerosis)
- Mechanical obstruction (Zenker diverticulum, thyromegaly)
- Skeletal muscle disorders (myasthenia gravis, muscular dystrophies, polymyositis)
- Miscellaneous (medications, radiation)

Esophageal dysphagia:

- Mechanical obstruction [carcinoma esophagus, benign strictures, webs and rings (Schatzki)]
- Achalasia cardia (achalasia, scleroderma)
- Gastroesophageal reflux disease
- Miscellaneous (diabetes, alcoholism)

If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.

1. You are Mr. Peter, age 50
2. Have difficulty in swallowing for past 3 months
3. Started with difficulty with solids
4. Progressing slowly
5. Started having difficulty in swallowing liquids recently
6. The food gets stuck behind the sternum; no problem with chewing and transferring into esophagus
7. Used to push food with a gulp of water; not able to do that anymore
8. History of regurgitation of food hours after intake
9. Heart burn present in lower part of chest for past 2-3 years; Taking plenty of antacids
10. Recent loss of weight. Nearly 10 pounds.
11. Recent loss of appetite
12. Never took any corrosive liquids accidentally or intentionally
13. No history of nausea or vomiting
14. No difficulty in breathing
15. No weakness in arms or legs
16. Other than heartburn, no other medical problems
17. No previous hospitalizations
18. Occupation: used to work as stock broker
19. Smokes – 1 pack/day for past 30 years
20. Alcohol – occasional glass of wine
21. Family history – no history of cancer or neurological diseases in the family
22. Other than antacids, not taking any other medications

Ask this question after the encounter, 'Doc, do I have cancer?'

case32 checklist

HPI:

1. Asked an open-ended question to describe about dysphagia
2. Asked about onset
3. Asked about exact location where the food is getting stuck
4. Asked whether symptoms are intermittent or progressive
5. Asked whether the dysphagia is for solids or liquids or for both
6. Asked which started first (solids or liquids)
7. Asked whether it is associated with pain
8. Asked about any relieving factors
9. Asked about any aggravating factors
10. Asked about episodes of choking sensation or regurgitation/aspiration
11. Asked about any nausea and vomiting (any hemoptysis)
12. Asked if I have/had heartburn
13. Asked about weight loss
14. Asked about loss of appetite
15. Asked about any difficulty in breathing
16. Asked about weakness of the arms or legs

PMH:

1. Asked about similar episodes in the past
2. Any other medical problems (reflux disease, neurological problems)
3. Asked if any history of accidental or intentional corrosive liquid intake is present

SH:

1. Asked about occupation
2. Asked about smoking
3. Asked about alcohol intake

FH:

- Any family history of cancer or neurological disorders

Meds:

- Asked if I am using any medications

Examination:

1. Informed me
2. Washed hands
3. Palpated neck for swelling
4. Examined my mouth and throat
5. Gave me water and asked to swallow
6. Palpated axilla and above my clavicles
7. Auscultated my abdomen
8. Palpated my abdomen deep and superficial
9. Auscultated lungs
10. Auscultated heart
11. Examined without gown and not through gown

Counseling:

1. Explained about physical findings and differential diagnosis
2. Explained further workup
3. Explained about importance of quitting smoking

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

D.D:

1. Carcinoma esophagus
2. Achalasia cardia
3. Reflux esophagitis
4. Stricture

Investigations:

1. CBC
2. Barium swallow
3. Esophagoscopy
4. Chest x-ray

case33 Scenario

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30 Yr. O/M came to HIV drug refill

Vitals

- Pulse-78/min
- B.P-120/75 mm of Hg
- Temp-98.8F
- R.rate-22/min

case33 SP

If the doctor asks you anything other than these just say 'no' (or) say things that are normal in daily routine life.

- You are Mr. Nathan, age: 30yrs
- You came for taking refill for Zidovudine.
- You have been taking it for past six months
- Taking 250 mg five times a day. Taking medications regularly.
- No problems with taking medications (no muscle weakness etc…)
- Not taking any other medications
- It was diagnosed 1year back. ELISA testing further confirmed by Western blot.
- No Cough

- No fever, No history of night sweats, no headache, vomiting, no eye problems
- No problems with swallowing
- No swelling anywhere in the body
- No history of diarrhea
- Vaccinations for Pneumonia taken last year
- Appetite is reduced
- Weight has reduced
- No depression, you are fine
- No white plaques in oral cavity
- No complaints of reddish papules over skin
- Using only bottled water
- No plans to travel in near future outside United States
- No history of any ulcer/ discharge on genitalia.
- No Allergies.
- No history of tingling, numbness in extremity and pain in abdomen
- Have multiple sexual partners. All are males.
- Using condoms.
- Attitude towards life is positive. Have informed his sexual partners about his HIV status.
- There is no one-take care of you, all your friends and family members abandoned you.
- Families' health is normal
- Smoking – No
- Alcohol- No
- Occupation: Working as a truck driver
- No illicit drug intake
- Not participating in any study

case33 checklist

History Taking (General Proforma)

1. Asked about the drugs that are presently taking
2. Asked about compliance
3. Asked about side effects of drugs (any stomach pain, muscle weakness)
4. Asked about breathing problems (cough, SOB)
5. Asked about fever
6. Asked about headache and vomiting
7. Asked about eye problems
8. Asked about oral ulcers and white patches
9. Asked any problems with swallowing
10. Asked about associated skin problems and rash
11. Asked about weakness and sensory problems in limbs
12. Asked about bowel problems (loose motions)
13. Asked about urinary problems
14. Asked about genital problems (ulcers, discharge)
15. Asked about support systems
16. Asked about symptoms of depression

Past History

1. Asked about past medical problems (high blood pressure, diabetes...)
2. Asked about history of allergies
3. Enquired about previous hospitalizations (surgery)
4. Asked about vaccinations
5. Enquired about any future travel ideas
6. Asked about family health.
7. Asked about appetite and changes in weight
8. Asked about smoking
9. Asked about alcohol
10. Asked about sexual history (in detail including contraception)
11. Asked whether I have informed my sexual partners about my HIV status

12. Asked about medications
13. Asked about occupation

Examination

1. Examinee washed hands
2. Palpated abdomen gently
3. Auscultated lungs and heart
4. Examined eyes with ophthalmoscope.
5. Checked sensory system in hand sand legs
6. Examined oral cavity
7. Examined without gown not through the gown

Counseling

1. Explained the physical findings
2. Explained further work up (Blood tests, viral titers, chest x ray)
3. Explained the importance of safe sexual practices and use of condoms to protect others
4. Explained the complications and how to deal with them
5. Explained the importance of vaccinations
6. Explained the availability of support systems

Communication Skills

1. Knocked before entering the room
2. Introduced himself and greeted warmly
3. Used my name to address me
4. Paid attention to what I said and maintained good eye contact.
5. Asked few open ended questions
6. Asked non leading questions
7. Asked one question at a time
8. Listened to what ever I said with out interrupting me in between
9. Used lay man's language
10. Used appropriate transition sentences
11. Used appropriate draping techniques

12. Summarized the history and explained physical findings
13. Expressed empathy, made appropriate reassurances
14. Asked whether I have any concerns/ questions.

D.D for this Case

1. HIV refill
2. Depending upon case (not here - PCP, Candida infection, CMV Retinitis, esophagitis)

Investigations

1. CBC with differential count
2. CD 4 count
3. Viral Load (HIV RNA PCR)
4. Chest X-ray
5. LFTs (Zidovudine Toxicity)

16-year-old female with amenorrhea

Vitals:

PR: 76/min

BP: 120/70 mmHg

RR: 16/min

Temp: 98.0 F (36.7 C)

Mental checklist of DD:

- Primary amenorrhea
- Secondary amenorrhea
- Pregnancy
- Anorexia nervosa
- Hyperprolactinemia
- Thyroid dysfunction
- Polycystic ovarian syndrome
- Stress
- Post pill amenorrhea
- Hypothalamic pituitary ovarian axis problems

Note: Both hypothyroidism and hyperthyroidism can present with amenorrhea.

case34 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

- You are Helen, 16-years-old
- Did not have periods for past 2 months
- Last period 2 months back
- Menarche - 3 years back
- Had regular periods since then
- 28-30 days cycle lasting 3-4 days
- Moderate bleeding

- Never had any abnormal vaginal discharge
- Periods were regular and normal until 2 months back
- Never become pregnant
- No nipple discharge; once in a while, mild headaches are there
- Lost weight of 10 pounds over last 6 months; unintentional
- Appetite is good
- You have final exams and lot of stress going on
- Single sexual partner, using condoms as contraception (sometimes you miss during safe periods)
- You are also having anxiety, but no palpitations, bowel problems, and thyroid problems (no hair loss, no voice change, no change in texture of skin)
- No other medical problems
- Never had pelvic inflammatory disease; no procedures done on your uterus
- Not a smoker
- Not an alcoholic
- No illicit drug use
- No allergies
- You do not take any other medications

Please ask this question somewhere in the case, 'Doc, am I pregnant?'

case34 checklist

HPI:

- Asked about the duration of amenorrhea
- Asked about menarche
- Asked about last menstrual period
- Asked about previous cycles duration and quantity of blood loss
- Asked about abdominal pain
- Asked about any vaginal discharge
- Asked whether I am sexually active
- Asked whether I am using any type of contraception

- Asked about chance of getting pregnant
- Asked about weight loss and loss of appetite
- Asked about stress at home or work
- Asked about thyroid symptoms (constipation/diarrhea, cold/heat intolerance)
- Asked about any nipple discharge (hyperprolactinemia)
- Asked about any headaches (prolactinoma)

PMH:

- Asked about any similar episodes in the past
- Asked about other medical problems (diabetes mellitus, kidney or thyroid problems or pelvic inflammatory disease)
- Past history of D and C

SH:

- Asked about smoking
- Asked about alcohol intake
- Asked about recreational drugs

All:

1. Asked about any allergies

Meds:

1. Asked about my medications

Examination:

- Informed me
- Washed hands
- Palpated abdomen superficially
- Palpated abdomen deep
- Palpated neck for masses
- Asked me to swallow
- Examined eye movements
- Examined hands for tremor
- Examined without gown, not through the gown

Counseling:

- Explained physical findings and differential diagnosis
- Explained further workup
- Explained the need of pelvic exam and breast exam

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Pregnancy
- Anorexia nervosa
- Thyroid dysfunction
- Hyperprolactinemia
- Hypothalamic-pituitary-ovarian problems

Investigation:

- Pelvic and breast exam
- Pregnancy test
- TSH
- Serum prolactin level
- USG abdomen, as needed (ovarian tumors)
- MRI brain, as needed (prolactinoma)
- LH and FSH levels, as needed (for polycystic ovarian disease)

case35 Scenario

35-year-old female with acute right lumbar and lower abdominal pain

Vitals

PR: 100/min

BP: 110/70 mmHg

Temp: 38.3 C (101 F)

RR: 16/min

Mental Checklist of DD:

1. Renal colic
2. Ovarian torsion
3. Urinary tract infection and pyelonephritis
4. Pelvic inflammatory disease
5. Mittelschmerz
6. Appendicitis
7. Threatened abortion
8. Ectopic pregnancy
9. Dysmenorrhea
10. Endometriosis
11. Fibroids

case35 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Joanna, age 35 years
2. Have lumbar and lower abdominal pain for the past day
3. Started suddenly over the right lumbar area and then progressed towards the pelvic area and lower back
4. Progressing since then and it is of 7-8/10 in severity
5. Sharp pain

6. Not comfortable in any position
7. No relieving factors
8. Having burning urination for the past 2-3 days
9. Passing slightly discolored urine
10. Having fever with chills for the past day
11. Also feeling nauseous, but did not vomit
12. No vaginal discharge or bleeding
13. Last menstrual period (LMP) was 20 days back; your menstrual cycles have become heavy these days, but no intermenstrual bleeding
14. You don't think you are pregnant; have 2 healthy children
15. Bowel movements regular
16. Had 2 episodes of urinary tract infections in the past 2 years, do not remember the medications that you used. Also, has a history of pelvic inflammatory disease 2 years ago.
17. Was treated as outpatient; never hospitalized in the past
18. Never had kidney stones
19. Single sexual partner; no problems with sexual intercourse
20. Using condoms
21. Smokes 1 packet per day for the past 8 years
22. Occasionally drinks alcohol
23. No allergies
24. Not taking any other medication
25. No illicit drug intake

Ask this question at the end of session, 'The pain is really hurting me, Doc. Please relieve my pain, Doc.'

case35 checklist

HPI:

- Asked about the onset of pain
- Asked about location
- Asked about intensity
- Asked about quality
- Asked about radiation

- Asked about aggravating factors
- Asked about relieving factors
- Asked about associated fever and chills
- Asked about nausea and vomiting
- Asked about urinary problems (burning, blood in urine, frequency)
- Asked about last menstrual period
- Asked about menstrual cycles
- Asked about sexual practices and multiple sexual partners
- Asked about vaginal discharge/bleeding
- Asked about bowel movements, such as constipation and diarrhea

PMH:

1. Asked about any similar episodes in the past
2. Asked about any past medical problems, such as urinary tract infections, pelvic inflammatory disease, kidneys stones
3. Asked about prior hospitalizations and surgery

SH:

- Asked about occupation
- Asked about smoking
- Asked about alcohol intake

Meds:

1. Asked if I remember what medications I used for urinary tract infection
2. Asked about my medications

Allergies:

1. Asked about any known drug allergies

Examination:

- Informed patient
- Washed hands
- Auscultated abdomen
- Palpated abdomen superficially
- Palpated abdomen deep
- Tested for rebound tenderness and rigidity

- Tested costovertebral angle tenderness
- Tested for appendicitis (Psoas test)
- Examined without gown, not through the gown

Counseling:

1. Explained physical findings and probable diagnosis
2. Explained that I need a pelvic examination
3. Explained the further workup

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

Investigation:

- Pelvic examination
- Pregnancy test
- CBC with differential
- Urinalysis and culture
- Ultrasound abdomen

DD:

- Renal colic
- Acute pyelonephritis
- Pelvic inflammatory disease
- Fibroid uterus

- Appendicitis

case36 Scenario

70-year-old male with insomnia

Vitals:

PR: 88/min

BP: 130/90 mmHg

RR: 16/min

Temp: 98 F (36.7 C)

Mental Checklist of DD:

- Depression
- Post-traumatic stress disorder
- Anxiety disorder
- Chronic pain syndromes
- Drug induced
- Age related sleep changes
- Thyroid problems
- Sleep apnea
- Restless leg syndrome

case36 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are David, age 72 years
2. Onset of insomnia: for past 2 months
3. Duration of sleep: 2-3 hours a night
4. Has difficulty falling asleep
5. Also has difficulty staying asleep
6. No nightmares
7. No recent traumatic event
8. Snores a lot at night; you do not know anything about a breathing

problem; you feel tired in the morning and get some headaches as well

9. Having chronic epigastric pain for the past 2 months, but it is very mild (1-2 on a 10 scale), and it is constant all the time and there are no aggravating and relieving factors and no radiation
10. Live alone, since the death of your wife (2 years); your son lives 5 miles away from you. Feeling emotionally lonely.
11. Do not have any feelings of guilt
12. Good family support
13. Appetite decreased for past 3 months
14. Slight loss of weight, 2-3 pounds
15. Occasionally feeling anxious
16. Not having any associated symptoms, like palpitations or sweating or dizziness
17. Decreased the regular daily activities to minimal
18. Bowel and bladder habits normal
19. No problems of hypo/hyperthyroidism
20. No recent hair loss
21. No tremor in the hands
22. No change in the voice
23. Not taking any caffeinated drinks before bed
24. Smoker – 30 years – 2 packs/day
25. Occasionally drinks beer
26. No family history of cancer
27. Admitted 3 months back in the hospital for unstable angina; takes aspirin, metoprolol, and sublingual nitroglycerine; previous doctor also gave lorazepam, as needed, for anxiety during your hospital stay.
28. Taking the medicines regularly
29. No recent change in medications

Ask this question, 'Doc, do I have any problem for not getting enough sleep?'

case36 checklist

HPI:

1. Asked about onset
2. Asked about duration of sleep
3. Asked if having difficulty falling asleep or staying asleep (Do you have difficulty falling asleep?)
4. Asked about sleep habits
5. Asked if having nightmares
6. Asked if having feelings of guilt
7. Asked about any recent traumatic events
8. Asked if feeling lonely or depressed
9. Asked if feeling anxious about anything
10. Asked if having any associated palpitations, sweating, or dizziness
11. Asked if I have pain any where in the body
12. Asked about snoring/breathing problems (Do you snore loudly or stop breathing at night?)
13. Asked about daytime sleepiness and morning headaches
14. Asked about loss of appetite and weight loss
15. Asked about constipation and diarrhea
16. Asked about daily activities

PMH:

1. Asked about similar episodes in the past
2. Asked about previous hospitalizations
3. Asked about other medical problems (anxiety, depression)

SH:

1. Asked about smoking
2. Asked about alcohol intake
3. Asked about excessive caffeine intake
4. Asked about family support

FH:

- Asked about family history of cancer

Medications:

- Asked about my medications

Allergies:

1. Asked about any known drug allergies

Examination:

1. Informed me
2. Washed hands
3. Asked me to open my mouth (to look for oropharyngeal aperture)
4. Palpated my neck for masses or swellings
5. Tested my reflexes and muscle strength
6. Auscultated my heart and lungs
7. Palpated abdomen superficially and deeply
8. Tested for lymph nodes enlargement

- Examined without gown, not through the gown

Counseling:

1. Explained the findings and probable diagnosis
2. Explained the workup
3. Explained the importance of keeping to a particular sleep schedule
4. Explained the importance of quitting smoking and offered help

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques

- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

1. Anxiety disorder
2. Drug induced
3. Depression
4. Sleep apnea
5. Occult medical illness (cancer of the pancreas)

Investigations:

1. CBC
2. Basic metabolic panel (Na, K, BUN, Cr, Co2, Cl)
3. TSH
4. Nocturnal polysomnography
5. Upper GI endoscopy and ultrasound abdomen

65-year-old male patient with difficulty urinating

Vitals:

PR: 92/min, regular

BP: 130/80 mmHg

RR: 16/min

Temp: 99 F (37.2 C)

Mental Checklist of DD:

1. Benign prostatic hyperplasia
2. Carcinoma of prostate
3. Stone in the urinary tract (obstructive)
4. Strictures of urethra
5. Carcinoma bladder
6. Sphincter dysfunction
7. Infection
8. Neurological dysfunction, like spinal cord trauma and diabetes
9. Drug induced (anticholinergics)

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Dawson, 65-years-old
2. Having difficulty in passing urine for the past 2 months
3. Having difficulty in initiating urination
4. The flow is intermittent
5. Have to strain to pass urine
6. Need to go to bathroom often
7. Getting up more frequently in the nights (5-6 times)
8. You feel like your bladder is not emptied properly

9. Never noted much urgency
10. Slight burning sensation
11. Noticed some blood in urine only one time
12. Do not have any pain
13. No fever
14. No change in bowel movements
15. Appetite is decreased recently and lost 10 pounds of weight from the past year
16. Did not notice any weakness in legs
17. No history of sexually transmitted diseases or urinary tract infections in the past
18. No history of trauma
19. Has history of diabetes mellitus and taking glyburide, and it is under control for the past 10 years
20. Is not taking any prescriptive drugs
21. Taking over-the-counter drugs, like Tylenol, occasionally, and vitamins
22. Never hospitalized before
23. No illicit drug use
24. Not a smoker
25. Drinks beer at least 2 cans per day
26. Family health - Father died of prostate cancer when he was 75

Ask this question, 'Doc, do I have prostate cancer?'

case37 checklist

HPI:

- Asked about onset
- Asked if difficulty is in initiating or maintaining the flow
- Asked about flow/stream (Have you had a weak urinary stream?)
- Asked about intermittency (How often do you have to stop and start again while urinating?)
- Asked about incomplete emptying (Have you had a sensation of not emptying your bladder completely after finishing the urination?)
- Asked about frequency of urination

- Asked about urgency
- Asked about straining
- Asked about nocturia
- Asked about burning sensation
- Asked if I noticed blood in urine at any time
- Asked about abdominal pain
- Asked about fever
- Asked about any weakness in legs
- Asked about any change in bowel movements
- Asked about change in weight or appetite
- Asked about any trauma to back

PMH:

- Asked about similar episodes in the past
- Asked about past history of sexually transmitted diseases or urinary tract infections
- Asked about previous hospitalizations
- Asked about other medical problems that I have (diabetes mellitus, kidney, prostate problems)

SH:

- Asked about smoking
- Asked about alcohol intake
- Asked about sexual practices
- Asked about occupation

FH:

1. Asked about family history of cancer

Allergies:

1. Asked about any known drug allergies

Medications:

1. Asked about medicines I am using

Examination:

- Informed me

- Washed hands
- Auscultated abdomen
- Palpated abdomen → Suprapubic area (superficial and deep)
- Palpated back (costovertebral angle)
- Tested reflexes in legs
- Asked me to perform rectal examination
- Examined without gown, not through the gown

Counseling:

- Explained physical findings and differential diagnosis
- Explained the workup
- Explained the importance of rectal examination

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Benign prostatic hyperplasia
- Prostatic carcinoma
- Carcinoma bladder
- Overflow incontinence
- Urinary tract infection

Investigations:

- Per rectal examination
- CBC with differential
- Urinalysis and urine culture
- Serum BUN, creatinine, blood sugar, and HbA1C
- Prostate specific antigen (PSA)
- Cystoscopy, as needed
- Ultrasound, as needed

Case38 Scenario

Case 38 scenario

45-year-old female complains of breathlessness and anxiety

Vitals:

PR: 94/min, regular
BP: 130/80 mmHg
RR: 22/min
Temp: 97 F (36.1 C)

Mental Checklist of DD:

1. Anxiety secondary to medical condition, e.g., hyperthyroidism, arrhythmias, pheochromocytoma
2. Substance abuse
3. Panic disorder
4. Generalized anxiety disorder
5. Adjustment disorder with anxious mood
6. Acute stress disorder or post traumatic stress disorder
7. Hypochondriasis
8. Malingering

case38 SP

*** If the doctor asks you anything other than these, just say 'no,' or say**

things that are normal in daily routine life.

1. You are Mrs. Elizabeth, 35-years-old
2. Having difficulty breathing occasionally for the past 3 months
3. Associated with palpitations, sweating
4. Comes about 2-3 times per week
5. Lasts for about 30 minutes
6. Occurs at any time, usually when I go out
7. Crowded places aggravate the symptoms
8. Slow breathing and relaxation leads to relief
9. Not associated with chest pain
10. I get a feeling as if I am going to die
11. As a result of these attacks, I stopped outdoor activities
12. You also worry too much about your kids' future even though they are doing well; you have a loving husband, but always doubt that he may leave you.
13. Some times you get diarrhea and some times you get constipation; difficult to predict
14. Did not notice any trembling hands
15. Did not notice any swelling or mass in the neck
16. Visited emergency department repeatedly, but no diagnosis reached
17. No other medical problems
18. Occupation → housewife
19. Do not smoke
20. Alcohol → Occasional glass of wine
21. Do not drink too much caffeine; just as usual
22. No illicit drug use recently; you have used marijuana when you were in college
23. No stress at home
24. Family support is good
25. Mother has a history of generalized anxiety disorder
26. Not taking any medications

27. Allergic to penicillin (rash)

Ask this question, 'Doc, do I have anxiety like my mom?'

case38 checklist

HPI:

- Asked about onset
- Asked about duration of attacks
- Asked if there are any other associated respiratory symptoms
- Asked if having chest pain
- Asked about feelings of fright
- Asked about fear of death
- Asked about other associated symptoms, like palpitations, dizziness, sweating, headache
- Asked about aggravating and relieving factors
- Asked about restriction of activities
- Asked if noticed any recent trembling of hands
- Asked if noticed any swelling or mass in the neck
- Asked about bowel movements
- Asked about family support

PMH:

- Asked about similar episodes in the past
- Asked about previous hospitalizations
- Asked about other medical problems (thyroid, etc.)

SH:

- Asked about occupation
- Asked about smoking
- Asked about alcohol intake
- Asked about illicit drug use

FH:

1. Asked about family history of medical or psychiatric disorders

Medications:

1. Asked about any medicines I am using

Allergies:

1. Asked about any known drug allergies

Examination:

- Informed me
- Washed hands
- Palpated neck for swelling
- Looked at my hands for tremor
- Auscultated my heart
- Auscultated my lungs
- Examined without gown, not through the gown

Counseling:

- Explained about workup and differential diagnosis
- Explained about relaxation techniques
- Explained about the importance of family support

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Panic disorder

- Generalized anxiety disorder
- Hyperthyroidism
- Substance abuse

Investigation:

- CBC
- EKG
- TSH
- Urinalysis
- Urine Tox screen

case39 Scenario

53-year-old male with a long history of epigastric pain

Vitals:

PR: 84/min
BP: 120/70 mmHg
RR: 16/min
Temp: 97 F (36.1 C)

Mental Checklist of DD:

1. Peptic ulcer
2. Gastritis
3. Esophagitis (GERD)
4. Carcinoma of esophagus, stomach, and pancreas
5. Chronic pancreatitis
6. Cholecystitis
7. Hepatitis

case39 SP

***If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Donald, 53-years-old
2. Have chronic epigastric pain for past 2 years
3. Occurs on and off for a period of a few months
4. Sharp localized pain
5. 5-7 in a scale of 10 in intensity
6. Food intake brings on the pain and also aggravates it; some times you woke up with heartburn in the middle of the night.
7. Antacids used to relieve the pain
8. Occasionally, the pain radiates to the back
9. Twice I had vomitings with streaks of blood; this happened 2 weeks ago
10. Appetite decreased slightly, and you feel that your stomach is always full
11. No restriction on spicy foods
12. Lost weight - about 14 pounds in last 6 months
13. Has been feeling abdominal bloating recently
14. Never had jaundice before
15. No change in bowel habits; occasionally notice black stools
16. Not a smoker
17. Drinks alcohol; 1-2 beers a day, for past 20 years
18. No other medical problems; never been hospitalized
19. Mother died from pancreatic cancer when she was at 60
20. Has been taking ibuprofen for knee pain; you have knee pain secondary to degenerative joint disease
21. No illicit drug use

Ask this question, 'Doc, why am I having this pain for such a long time? Is it not curable? Please relieve my pain, Doc.'

case39 checklist

HPI:

- Asked about onset of pain
- Asked about location of pain

- Asked about intensity of pain
- Asked about quality of pain
- Asked about aggravating factors (especially, in relation to food)
- Asked about relieving factors
- Asked about radiation
- Asked about associated symptoms, like nausea, vomiting, heart burn
- Asked if there was any blood in the vomitus
- Asked about bowel habits
- Asked about black stools or blood in the stools
- Asked about loss of appetite and weight
- Asked about postprandial fullness or early satiety
- Asked if I had jaundice at any time

PMH:

- Asked about similar episodes in the past
- Asked about previous hospitalizations
- Asked about past medical problems (stomach ulcer, pancreas problems, liver problems)

SH:

- Asked about occupation and dietary habits (spicy food intake)
- Asked about smoking
- Asked about alcohol intake
- Asked about illicit drug use

FH:

- Asked about family history of esophageal, gastric, pancreatic, etc., cancer

Allergies:

- Asked about any known drug allergies

Medications:

- Asked about my medications, especially NSAIDs (prescription and over-the-counter)

Examination:

- Informed me
- Washed hands
- Draped appropriately
- Auscultated abdomen
- Palpated abdomen superficially
- Palpated abdomen deep
- Palpated axilla and above clavicle for lymph nodes
- Examined without gown, not through the gown

Counseling:

- Explained physical findings and differential diagnosis
- Explained further workup
- Explained the importance of abstinence from alcohol
- Offered help

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Gastritis
- Peptic ulcer

- GERD
- Gastric carcinoma
- Chronic pancreatitis

Investigation:

- CBC with differential
- Endoscopy
- Serum amylase and lipase
- Liver function tests (albumin; bilirubin, direct and indirect; AST; ALT; alkaline phosphatase)
- Fecal occult blood testing
- USG or CT abdomen, as needed
- H. Pylori breath test, as needed

case40 Scenario 

45-year-old male complaining of bloody vomiting

Vitals:

PR: 90/min, regular

BP: 100/60 mmHg

RR: 18/min

T: 98.0 F (36.7 C)

Mental Checklist of DD:

- Gastric ulcer
- Duodenal ulcer
- Esophageal and gastric varices
- Mallory-Weiss tears
- Gastritis
- Erosive esophagitis
- GI malignancy
- Vascular ectasia

***If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

History of presenting illness:

- You are Mr. George, age 55 years
- Your main complaint is bloody vomiting. The first episode was 2 hours ago while you were working at your office, and the second episode was 30 minutes ago. Then, you got scared and came to the emergency room. You have never had this problem before.
- The vomiting was associated with epigastric pain (above the umbilicus). Both the vomiting and abdominal pain occurred almost simultaneously.
- You did not have any prior episodes of retching or coughing before the bloody vomitus. The first vomit, itself, was a bloody vomiting. It was bright red in color. The quantity was around a cupful.
- The epigastric pain was 6-8/10 in severity, burning in quality, and radiating to back. Actually, you have had on-and-off heartburn over the past 2 years, but you never consulted the doctor for that. You often take antacids and eat some crackers, usually relieving your pain; but, recently, it has been getting worse.
- Drinking caffeinated beverages and alcohol aggravates your pain.
- You are feeling slightly dizzy since vomiting occurred.
- You have also noticed black-colored (dark tarry) stools once in a while; otherwise, your bowel habits are normal and you do not have constipation or diarrhea.
- No problem with your urination; no blood in the urine.
- You did not notice any fever.
- Your appetite is good; you did not lose any weight.

Other medical problems:

- Your other medical problems include high blood pressure and chronic tension headaches.

- You do not have any other medical problems, except high blood pressure and tension headaches.
- You have never been admitted in the hospital and have never had any surgeries.

Social history:

- You are working as a marketing manager in a sales company. You have a little bit of stress at work.
- You smoke around 2 packs per day for the past 25 years. You have never tried quitting.
- You also drink alcohol, around 2-3 beers per week for the last 10 years.

Family history:

- There is no family history of liver disease or bleeding disorders.
- All your family members are healthy.

Medications:

- You use ibuprofen as needed for tension headaches.
- Also, you take hydrochlorothiazide for high blood pressure.
- You do not take any other medications, including recreational drugs.

Allergies:

- You have no known drug allergies.

Ask this question, 'Doc, will I die from bleeding? Is it a cancer?'

case40 checklist

HPI:

- Asked an open-ended question about the chief complaint
- Asked about the onset of vomiting (if not covered in the chief complaint)
- Asked about the color of the vomit
- Asked about the quantity of blood vomited

- Asked about any prior symptoms, such as coughing or retching
- Asked about any associated abdominal pain
- Asked about the quality of the pain
- Asked about the exact location of the pain
- Asked about the intensity of pain on a scale of 1-10
- Asked about any radiation of the pain
- Asked about prior episodes of pain (choric epigastric pain/heart burn)
- Asked about the aggravating factors of the pain
- Asked about the relieving factors
- Asked about dizziness
- Asked about fever
- Asked about melena or bright blood per rectum
- Asked about bowel habits
- Asked about hematuria or any other source of bleeding

PMH:

- Asked about prior similar episodes and other medical problems (liver problems, stomach ulcers)
- Asked about prior hospitalizations
- Asked about prior surgeries

SH:

- Asked about job description
- Asked about stress at work and in family
- Asked about smoking
- Asked about alcohol intake

FH:

- Asked about the family history of cancer, liver problems, or bleeding disorders

Medications:

- Asked about all the medications currently used
- Asked about the illicit/recreational medication use

Allergies:

- Asked about any known drug allergies

Examination:

- Informed me
- Examinee washed hands
- Draped appropriately
- Checked my eyes for pallor and jaundice
- Examined my mouth and pharynx
- Palpated my neck and supraclavicular region for lymph nodes
- Listened to my heart and lungs
- Auscultated my abdomen
- Palpated my abdomen superficially
- Palpated my abdomen deeply
- Examined my extremities
- Examined without gown, not through the gown

Counseling:

- Explained physical findings and probable diagnosis
- Explained further workup (CBC with differential, electrolytes, endoscopy, and possible hospitalization)
- Explained the importance of quitting smoking and alcohol
- Advised me not to take ibuprofen
- Offered help and support

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings

- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Gastric ulcer
- Duodenal ulcer
- Gastritis
- Erosive esophagitis
- GI malignancy

Investigation:

- CBC with differential
- Serum electrolytes (Na, K, Hco3, Cl, BUN, Creatinine)
- Upper GI endoscopy
- Liver function tests
- Helicobacter pylori serology

case41 Scenario 

60-year-old male complains of dizziness

Vitals:

PR: 80/min

BP: 140/90 mmHg

RR: 16/min

Temp: 97.0F(36.1)

Mental Checklist of DD:

1. TIA or stroke
2. Drug induced
3. Coronary artery disease
4. Autonomic dysfunction
5. Postural hypotension
6. Congestive heart failure
7. Arrhythmias
8. Hypoglycemia

9. Intracranial pathology
10. Ear problems
11. Anemia

case41 SP

SP's Notes

*If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.

- You are Robert, 60-years-old
- Having dizziness for past 4 days
- Occurs occasionally
- Lasts for 2-5 minutes
- More on getting up from sitting position
- Lying down will help reduce the dizziness
- Sometimes associated with palpitations or sweating
- No chest pain
- Never lost consciousness during these episodes
- This time noticed weakness in right lower leg and lasted for 10 minutes and resolved spontaneously; no headache, nausea, or vomiting
- No change in bowel or bladder habits

Other medical problems:

- You have diabetes for 15 years and take glyburide twice daily; you check blood sugar twice daily, and it is in the range of 120-160 mg/dL.
- You have high BP from the past 10 years. One week back, medication for BP control was changed from atenolol to terazosin (alfa blocker).
- So far, no heart problems and never had any strokes.

Social history:

- Smoker for 30 years, 2 packs/day
- Not an alcoholic
- Exercise regularly
- Occupation - clerk in food store
- Lives with wife; she is healthy

Medications:

- Only terazosin and glyburide
- Taking medication regularly, as prescribed

Allergies:

- You have no known drug allergies

Ask this question, ‘ Doc, did I have stroke?’

case41 checklist

HPI:

- Asked an open-ended question about the dizziness (What do you mean by dizziness? Can you please explain to me a little more about it?)
- Asked about the onset
- Asked about duration
- Asked about relation to posture
- Asked whether it is continuous or intermittent (Does it resolve completely between the attacks?)
- Asked about aggravating and relieving factors
- Asked if there are any associated symptoms (visual changes, headache, tingling/numbness, weakness)
- Asked if I ever lost consciousness
- Asked about vertigo
- Asked about ear problems, such as loss of hearing

ROS:

- Asked if there is any change in bowel or bladder habits
- Asked about chest pain and palpitations
- Asked about nausea and vomiting (for intracranial pathology)

PMH:

- Asked about similar episodes in the past
- Asked about past medical problems (diabetes mellitus or stroke or heart problems)
- Asked about previous hospitalizations and surgeries

SH:

- Asked about smoking
- Asked about alcohol intake
- Asked about the living situation (who else lives with you at home?)

Allergies:

- Asked about any known drug allergies

Meds:

- Asked about all my medications
- Asked if there was any recent change in medication or dosage

Examination:

- Informed me
- Washed hands
- Checked BP on both arms in sitting, standing, and lying position (need not be necessary, but tell the patient that you need to record BP in all limbs)
- Checked motor power and sensations in all limbs
- Checked reflexes
- Examined cranial nerves
- Performed Romberg's test
- Checked 2 cerebellar function tests
- Checked gait
- Checked carotid arteries for bruit
- Auscultated heart
- Examined without gown, not through the gown

Counseling:

- Tell that you need to record BP in all limbs
- Explained physical findings and probable diagnosis

- Explained further workup
- Explained the importance of quitting smoking and offered help
- Explained the effects of medication change
- Congratulated me for doing regular exercise and asked me to continue doing it regularly

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Drug induced postural hypotension
- Autonomic dysfunction from diabetes
- Hypoglycemia
- Arrhythmias
- Transient ischemic attacks
- Coronary artery disease

Investigations:

- Orthostatic BP checkup
- CBC
- Doppler carotid study
- Blood glucose and HbA1C
- Serum electrolytes (Na, K, Cl, BUN, Creatinine)

- EKG and Holter monitoring
- CT scan of the head, as needed

case42 Scenario

30-year-old male with new onset of seizure

Vitals:

PR: 82/min, regular

BP: 120/80 mmHg

RR: 18/min

T: 99.0 F (37.2 C)

Mental Checklist of DD:

- Seizures (secondary to head trauma, infections, drugs, metabolic disorders)
- Hypoglycemia
- Syncope
- Migraine
- Stroke
- Space occupying lesions
- Alcohol or drug withdrawal

case42 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

1. You are Keith, age 30 years
2. Had an episode of seizure a few hours ago; the episode lasted around 3 minutes, but you were unconscious probably about 20 minutes. You felt a little nauseous before the onset of seizures, and then you don't know what happened, but your co-workers told you that you had jerky movements for a couple of movements.
3. Did not pass urine or feces during the episode
4. You bit your tongue during the episode

5. You have been noticing some weakness in the right hand for the past 3 months
6. Once in a while, you get very mild headaches, but these days your headache is constant and more in severity
7. Having mild fever, cold and flu-like symptoms for the past couple of days
8. No history of ear discharge or sinusitis
9. No pain in the neck
10. No history of head trauma

Other medical problems:

1. You have type-1 diabetes and have been on insulin for the past few years. You do not think this is an episode of hypoglycemia, because you know how that looks like.
2. No other medical problems

Social history:

1. Occasionally drinks alcohol. Last drink was 2 days ago.
2. No smoking history
3. Never used any illicit drugs
4. Occupation - Clerk in postal department

Family history:

1. There is no family history of seizures

Medications:

2. Insulin NPH type 10 units in AM and 8 units at PM. Usually checks blood sugar 2 times a day.

Allergies:

3. No known drug allergies

Ask this question, 'Doc, do I have a brain tumor?'

case42 checklist

History:

1. Asked me an open ended question to describe the seizures
2. Asked about aura (prodromal symptoms)

3. Asked whether I was conscious or unconscious
4. Asked about the systemic symptoms such as palpitations, chest pain etc
5. Asked about the automatisms such as lip smacking
6. Asked about the fecal or urinary incontinence
7. Asked about any biting of tongue
8. Asked about the duration of episode
9. Asked about the postictal confusion

ROS:

1. Asked about headache past, or present
2. Asked about vomiting
3. Asked about any weakness in the extremities
4. Asked about a fever
5. Asked about neck pain or stiffness
6. Asked about frequent ear infections or sinusitis

PMH:

1. Asked about similar episodes in the past
7. Any previous history of meningitidis or encephalitis or stroke
8. Asked about any recent trauma to my head
9. Any other medical problems such as diabetes

SH:

10. Asked about alcohol intake or withdrawal
11. Asked about smoking
12. Asked about illicit drug intake
13. Asked about the occupation

FH:

14. Asked about the family history of seizures

Medications:

15. Asked about any medication use (particularly insulin, oral hypoglycemics)

Allergies:

16. Asked about any known drug allergies

Examination:

1. Informed me
2. Examinee washed hands

3. Tried to bend my neck
4. Checked motor power in all limbs
5. Checked reflexes of all the limbs
6. Checked sensations in all limbs
7. Examined all the cranial nerves
8. Examined my eyes with ophthalmoscope
9. Examined my ears with otoscope
10. Auscultated heart
11. Auscultated lungs
12. Palpated the abdomen for organomegaly (metabolic disorders)
13. Quickly looked at the skin for pigmentation
1. Examined without gown, not through the gown

Counseling:

1. Explained physical findings and probable diagnosis
2. Explained further work up
3. Offered support to cope up with the situation

Communication Skills:

1. Knocked before entering the room
2. Introduced himself and greeted warmly
3. Used my name to address me
4. Paid attention to what I said and maintained good eye contact
5. Asked few open-ended questions
6. Asked non-leading questions
7. Asked one question at a time
8. Listened to what ever I said with out interrupting me
9. Used lay man's language
10. Used appropriate transition sentences
11. Used appropriate draping techniques
12. Summarized the history and explained physical findings
13. Expressed empathy, gave appropriate reassurances
14. Asked whether I have any concerns/ questions.

DD:

1. Seizures secondary to brain tumor
2. Seizures secondary to hypoglycemia
3. Alcohol withdrawal seizures
4. Seizures secondary to encephalitis
5. Seizures secondary to meningitis

Investigation:

1. CBC with diff
2. Serum electrolytes (Na, K, Cl, Co2, BUN, Cr, Ca, Mg)
3. LFTs and blood glucose
4. Urine analysis and Tox screen
5. CT scan of head
6. Lumbar puncture
7. EEG

case43 Scenario

A 23-year-old male with rectal bleeding

Vitals:

PR: 90/min, regular

BP: 110/60 mmHg

RR: 18/min

T: 101.0 F (38.3 C)

Differential diagnosis of lower GI bleed in an young patient:

- Anal fistula/fissure
- Inflammatory bowel disease
- Infectious colitis
- Neoplasm
- Vascular ectasia
- Gonococcal proctitis
- Hemorrhoids

Differential diagnosis of lower GI bleed in an elderly patient:

- Diverticulosis
- Angiodysplasia
- Malignancy/polyp
- Ischemic colitis
- Inflammatory bowel disease

case43 SP

*** If the doctor asks you anything other than these, just say 'no,' or say things that are normal in daily routine life.**

- You are Steve, age 23 years
- Having bleeding per rectum for past 3 days
- Started mildly with blood streaks in stools for past one month; progressed over 3 days to frank blood in stools; never had black stools.
- Associated with mild (2-3/10), crampy lower abdomen pain
- Suffered from chronic constipation for past 5 years. Have to strain a lot while defecating. Also, you use to have severe pain sometimes when defecating, but the bowel movements increased in frequency to 3 times a day recently.
- No nausea or vomiting
- Having mild fever (100 F) without chills for the past 4-5 days
- No recent change in weight or appetite
- No similar episodes in the past. Never admitted in the hospital before.
- Do not eat much vegetables or fruits
- You are working at local restaurant. No illicit drug use.
- Multiple female sexual partners; no homosexual activity; does not always use condoms.
- Not a smoker; not an alcoholic.
- Father died from colon cancer at the age of 65
- Not using any medications chronically
- You have no known drug allergies

case43 checklist

History:

- Asked an open-ended question regarding the bleeding
- Asked me to explain whether it is a bright red blood or stool mixed with blood
- Asked about the onset (if not covered in open-ended question)
- Asked about progression
- Asked about quantity of bleeding
- Asked about pain during defecation
- Asked about tenesmus
- Asked about abdominal pain
- Asked about any prior episodes of melena
- Asked about nausea and vomiting
- Asked about the bowel habits (any diarrhea and constipation)
- Asked about loss of appetite and changes in weight
- Asked about fever and chills

PMH:

- Asked about other medical problems (history of polyp or cancer or inflammatory bowel disease or radiation exposure)
- Asked about previous hospitalizations and prior procedures

SH:

- Asked about occupation
- Asked about illicit drug use
- Asked about smoking
- Asked about alcohol intake
- Asked about dietary habits
- Asked about sexual practices (especially, homosexual)

FH:

- Asked about any family history of colorectal cancer

Meds:

- Asked about any medications I am using (especially, aspirin)

Allergies:

- Asked about any known drug allergies

Examination:

- Informed me
- Washed hands
- Draped appropriately
- Auscultated my abdomen
- Palpated my abdomen superficial
- Palpated my abdomen deep
- Attempted to elicit rebound tenderness
- Asked to perform per rectal examination
- Examined without gown, not through the gown

Counseling:

- Explained the physical findings and probable diagnosis
- Explained further workup (CBC, rectal exam, anoscopy)
- Explained the importance of safe sexual practices
- Offered on going support

Communication Skills:

- Knocked before entering the room
- Introduced himself and greeted warmly
- Used my name to address me
- Paid attention to what I said and maintained good eye contact
- Asked few open-ended questions
- Asked non-leading questions
- Asked one question at a time
- Listened to whatever I said without interrupting me
- Used lay man's language
- Used appropriate transition sentences
- Used appropriate draping techniques
- Summarized the history and explained physical findings
- Expressed empathy, gave appropriate reassurances
- Asked whether I have any concerns/questions

DD:

- Inflammatory bowel disease
- Anal fistula/fissure
- Proctitis
- Infectious colitis
- Neoplasm (polyp)

Investigations:

- Rectal examination and fecal occult blood testing (FOBT)
- CBC and ESR
- Anoscopy
- Sigmoidoscopy/colonoscopy
- Abdominal x-ray