Grading Rubric

1. **40% = History questions**
2. **30% = physical exam**
3. **10% = differential diagnosis list**
4. **10% = ranking the differential diagnosis**
5. **10% = lab test**
6. **0% = science exercises**
7. **0% = management plan – faculty scores this.**

Case Help

HISTORY:

- Patient interview reminder sheet- document in key findings
- "Good Question" means you asked a required question

Step 1: Start by asking 2 open ended patient centric questions:

1. How can I help you today?
2. Any other symptoms or concerns?

Step 2: Obtain an HPI using "OLDCARTS"

- **O = Onset; circumstances surrounding start of symptom**
- **L = Location, radiation**
- **D = Duration**
- **C = Characteristics (sharp, dull, cramping)**
- **A = Aggravating**
- **R = Relieving**
- **T = Treatments**
- **S = Severity**

Step 3: PMH

- No patient record – Obtain history
- Have patient record – Update allergies, medications, OTC drugs

Step 4: FH

- No patient record – Obtain history

Step 5: SH

- No patient record- obtain history
- Have patient record- Update if major changes in living situation, death of partner, loss of job etc.

Step 6: ROS

- Questions for systems not addressed in HPI
- Choose ROS for the body systems you do not have information on. Use the large multipart questions

Physical Exam

- Do those physical assessment maneuvers as needed
- Choose ROS for those body systems you do not have information on. Use large multipart questions.

Assessment

- Organize key findings list by selecting the MSAP (Most significant active problem).
- Mark other findings as; related, unrelated, unknown, PMH/resolved.

Problem Statement

- Short summary of patient's presentation. Should contain: 1. Demographic description, 2. Chief complaint, 3. Hx and PE key findings, 4. Risk factors. Keep it concise.

Differential Diagnosis

- List disease you are considering Prior to ordering tests.

Tests:

- Determine what tests are needed to rule in or rule out each diagnosis on authors corrected list.
- Review authors corrected list of test results.

Final Diagnosis

- Select a final diagnosis or diagnoses.

Treatment plan

- Write a treatment plan following your instructors' guidelines.

Gear head exercises

- Complete exercises found throughout the case (look for the brain with gears icon in steps of the case)

Summary

- Proceed all the way to the "Summary" tab.
- Submit your case and press the "see evaluation" button to see your first evaluation.

Paisley Ward

16 y/o

5’5 (165cm)

150.0lb (68.2kg)

BMI 25

A&Ox4

Reason for encounter: Cough and SOB

Vital Signs

Temp: 37.0 (98.6)

Pulse: 88 bpm, rhythm: regular, strength: normal

BP L/arm 112/82, R/arm 114/80, assessment: normal, pulse pressure: normal

RR:26 bpm, rhythm: regular, effort: unlabored

SpO2: 94%

3 yr ago visit:

Reason: For Physical examination

Psych: stress at home with financial situation of family. No anxiety or SI

PMH: Eczema: uses moisturizer daily no flares for several yrs.

Hosp/Surg: Normal birth, full term, no medical problems. No major accidents or injuries. No surgeries.

Prev health: last check up 1 yr ago. UTD on all immunizations

Meds: None

Allg: NKDA

Social:

Lives at home with mother and father. Only child. Father lost job, works odd jobs to pay bills. Mother works at fast food restaurant. Evicted from home looking for place to live.

Denies past/present use of alcohol, tobacco, or illicit drugs. Never been sexually active. States she does get sad sometimes due to her family’s recent financial and living situation but she does not feel like she is depressed. She denies SI.

FHX: Father: Eczema, otherwise healthy, Mother: no medical problems, No other significant family history.

HISTORY Questions:

Skin: pink, warm, moist

1. ***How can I help you today?***
   Cough for the last three weeks which has been getting worse. I've also had SOB when walking to my next class at school. I have to stop and take a break.
2. ***Do you have any other symptoms or concerns we should discuss?***
   No, but I did have a runny nose and congestion 3 weeks ago. The congestion went away in a week but the cough is still there.

   HPI: Cough:
3. ***Are you coughing up any sputum?***
   No
4. ***Does anything make your cough better or worse?***
   Not really, it has been constant but has been getting worse over the past three days and seems to be worse at nights.
5. ***What treatments have you had for your cough?***
   Nothing

   PMH:
6. ***Do you have any allergies?***
   No
7. ***Are you taking any prescription medications?***
   No
8. ***Are you taking any OTC medications or herbals?***
   No
9. ***Are your immunizations UTD?***
   I assume so

   USED Hint
   3: Reason for encounter Sx/Sx characteristics
   3: Associated symptoms
   2: SH- DONE

SH:

10. **Do you now or have you ever smoked or chewed tobacco?**
    No
11. **Are you exposed to 2nd hand smoke?**
    Yes, dad lost his job 3 yrs ago so he has been doing odd jobs since then. We had to move to an older building and it has cockroaches in it. Also neighbors smoke inside the building so I always smell smoke everywhere.

    ROS: Associated s/s

12. ***Do you wheeze?***
    Im not sure
13. ***Does your chest feel tight or heavy?***
    Yes, actually that's the right way to describe it. Tight that is. Just a little bit.
14. ***Do you have any pain or other symptoms associated with your cough?***
    No pain but I am getting out of breath that is maybe related.

    HPI: Breathing: SOB
15. **When did you first notice feeling SOB?**
    This has been happening for 3 days now and its made me a little scared.
16. **Does anything make your SOB better or worse?**
    It gets a little better when I stop walking and rest for a bit. It's a little worse at night.
17. **Has there been any change in your SOB over time?**
    Last few yrs, I have had a cough and SOB but it got better after a few days so I din not get checked. This time its lasting longer. I also didn't want to stress out my parents bc they have to work so much so I never told them.

EHR

PMH: Eczema

HOSP/SURG: No previous hospitalizations. No major accidents or injuries and no surgical history. Full term and normal birth.

Prev: Last physical was 3 years ago. She believes she is up to date on immunizations. Patient reports being exposed to second hand smoke in the building that she lives in.

MEDS: No prescription, OTC or herbal medications.

Allergies: No known drug allergies

Social history: Patient lives in an older building with her parents. She is exposed to second hand smoke by her neighbors in the building. She denies any using tobacco in any form.

Family history: Father: Eczema, otherwise healthy, Mother: no medical problems, No other significant family history.

History form: