Standardized Patient Form

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| ***Role Player****: Asking someone to imagine that they are either themselves or another person in a particular situation. ​Role Players behave exactly as they feel that person would, thus would not need a case developed.*  ***Structured Role Play:*** *A person who has been provided a prepared script on one element of a scenario which articulates a learning objective.​ Improvisation meets structure.​*  ***Embedded Participant​:*** *An individual who is trained or scripted to play a role in a simulation encounter in order to guide the scenario based on the objectives.​*  ***Simulated Patient:*** *A person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician. In performing the simulation, the SP presents the ‘Gestalt’ of the patient being simulated; not just the history, but the body language, the physical findings and the emotional and personality characteristics as well.*  ***Standardized Patient:*** *Individuals who are trained to portray a patient with a specific condition in a realistic, standardized and repeatable way (where portrayal/presentation varies based only on learner performance are trained to behave in a highly repeatable or standardized manner in order to give each learner a fair and equal chance.*  *\*Please consider the lines between the six applications as porous and not as hard lines that prevent movement between applications . Source: Comprehensive Healthcare Simulation; Implementing Best Practices in Standardized Patient Methodology, Chapter 5 The Human Simulation Continuum: Integration and Application.* | |
| **Level of Standardization** | [ ] Standardized Patient  [ ] Simulated Patient |
| **Standardized Patient Objectives** | Your challenge as the **Standardized Patient** is multifold:   * To appropriately and accurately reveal the facts about the role being portrayed. * To improvise only when necessary and in a manner that is consistent with the overall tone/content of the case. * Maintain the realism of the simulation i.e., stay in character. * Evaluate learners fairly based on how they performed in this encounter. * Provide patient perspective in feedback. |

**Patient Name:** Sarah Johnson

**Age:** 55

**Gender:** Female

**Chief Complaint:** “I’ve been feeling really tired and thirsty lately, and I’ve been going to the bathroom a lot.”

**Presentation and Resulting Behaviors (e.g. body language, non-verbal communication, verbal characteristics)**

**Examples:**

**Affect: pleasant/cooperative/irritated**

**Speech: verbose/terse/limited**

***Note: include any changes to presentation as case progresses***

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| * **Affect:** Slightly anxious but cooperative. * **Speech:** Moderate; not overly talkative, but willing to share concerns. * **Body Language:** Appears somewhat tired, fidgeting with hands occasionally. May shift in her seat. * **Facial Expression:** Slightly worried but trying to stay calm. * **Physical Appearance:** Overweight, appears middle-aged but in good general health otherwise.   Changes as case progresses:   * Initially somewhat reserved but becomes more open and detailed as questions are asked. * May show signs of discomfort as the visit progresses, particularly when asked about complications or lifestyle changes. |

**Opening Statement, Open-Ended Questions, and Guidelines for Disclosure**

Note: this section is to give the SP guidance on how to answer open-ended questions. Scripted answer(s) to initial open-ended questions like “what brings you in today?” and “Can you tell me more?” should go in Box A. Further open-ended questions like “anything else going on?” should go in box B below, as well as any information the SP should volunteer at the first given opportunity. Box C is for information that the SP should freely offer, but wouldn’t consider mentioning until the learner introduces a relevant topic. Box D is for information that needs to be withheld unless specifically asked, (e.g. things the patient doesn’t remember until prompted or things the patient may feel shame about).

*Example: let’s say the patient’s roommate is ill. If the patient is having similar symptoms, that information probably goes in box B–it’s highly relevant to the patient and on the top of their mind. If the patient has somewhat differing symptoms, the information might go in box C and could be revealed if the learner brings up living situation, social support, or sick contacts. If the patient would assume the roommate’s illness is unrelated, the information might go in box D and only be revealed when the learner asks about sick contacts.*

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| **Opening Statement(s)** | I’ve been feeling really tired lately, and I have a lot of thirst. I’m also getting up multiple times at night to use the bathroom. I’m worried something’s wrong.” |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · “I’ve been having trouble focusing at work, and sometimes I feel dizzy when I stand up quickly.”  · “I’ve noticed that my vision seems blurry, especially when I’m reading.” |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · I’ve been gaining weight over the past few years, but it’s been more noticeable recently.”  · “I know that diabetes runs in my family, but I didn’t think it would happen to me.” |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | · Does not initially mention that her father had diabetes and died of complications, feeling ashamed about it.  · She avoids talking about her diet habits, especially the consumption of sugary snacks and high-carb foods. |

**Sample Healthcare Interview & Physical Exam Format:**

**History of Present Illness (HPI):**

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| **Quality/Character** | “I feel really thirsty all the time, and I can’t seem to get enough to drink. I’m also extremely tired, even though I’m sleeping okay at night.” |
| **Onset** | “It started about a month ago, but I thought it was just stress from work. But it’s only been getting worse.” |
| **Duration/Frequency** | “The thirst has been constant for the past few weeks. I’m getting up at least 3-4 times a night to use the bathroom, and I feel like I’m always drinking something.” |
| **Location** | “It’s not really a pain, but more like an overall feeling of being unwell.” |
| **Radiation** | None reported. |
| **Intensity (e.g. 1-10 scale for pain)** | “On a scale from 1 to 10, my fatigue is about a 7. I can’t seem to shake it, no matter what I do.” |
| **Treatment (what has been tried, what were the results)** | “I’ve been drinking a lot more water and trying to get more rest, but nothing seems to help.” |
| **Aggravating** **Factors (what makes it worse)** | “Nothing in particular seems to make it worse, but I do feel worse when I skip meals or eat too much sugar.” |
| **Alleviating** **Factors (what makes it better)** | “Drinking water and resting help a little, but it doesn’t last long. |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | “I’ve been more stressed at work lately, but I don’t think that’s the main issue.” |
| **Associated** **Symptoms** | Blurry vision, dizziness when standing, frequent urination. |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | “It’s starting to interfere with my job and daily life. I’m worried it’s something serious. I’m afraid it’s related to diabetes like my father had.” |

**Review of Systems: (list any additional pertinent positives and negatives from these systems: Constitutional, Skin, HEENT, Endocrine, Respiratory, Cardiovascular, Gastrointestinal, Urinary, Reproductive, Musculoskeletal, Neurologic, Psychiatric/Behavioral)**

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| · **Constitutional**: Fatigue, weight gain, excessive thirst, increased urination.  · **Skin**: No rashes or lesions.  · **HEENT**: Blurry vision, no headaches or visual disturbances beyond blurriness.  · **Endocrine**: No heat or cold intolerance, no excessive sweating.  · **Respiratory**: No shortness of breath, cough, or chest tightness.  · **Cardiovascular**: No chest pain, no palpitations.  · **Gastrointestinal**: No nausea, vomiting, or changes in appetite.  · **Urinary**: Increased frequency of urination, especially at night.  · **Reproductive**: No abnormal vaginal bleeding, regular menstrual cycle.  · **Musculoskeletal**: No joint pain or swelling.  · **Neurologic**: Occasional dizziness when standing up quickly, no headaches or numbness.  · **Psychiatric/Behavioral**: Some anxiety and stress due to work, no history of depression. |

**Past Medical History (PMH): (fill in any relevant fields)**

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| **Illnesses/Injuries (chronic or otherwise relevant)** | No chronic illnesses except for a recent history of fatigue and thirst. |
| **Hospitalizations** | None. |
| **Surgical History** | None. |
| **Screening/Preventive (including vaccinations /immunizations)** | Last physical exam two years ago, regular mammogram and colonoscopy as per age. |
| **Medications (Prescription, Over the Counter, Herbal/Dietary Supplements)**  **Include: medication name, dosage strength, dosage form, route of administration, frequency of administration, duration of therapy, indication** | Currently not on any regular medications, uses over-the-counter pain relievers occasionally for headaches. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | · **Medication**: No known drug allergies.  · **Environmental/Food**: No known food or environmental allergies. |
| **Gynecologic History** | · **Menstrual History**:   * · **Menarche**: Onset of menstruation at age 13. * **Menstrual Cycle**: Regular cycles, 28 days, lasting 4-5 days. * **Menstrual Flow**: Moderate flow, no significant changes in the amount or duration in the past year. * **Menstrual Symptoms**: Mild cramps around day 1 of menstruation, manageable with over-the-counter pain relievers. * **Last Menstrual Period (LMP)**: 1 week ago (regular).   · **Contraceptive History**:   * · **Current Contraceptive Method**: None currently. She has not used contraception for the past 10 years after deciding to stop having children. Her last child was born 20 years ago. * **Previous Contraception**: Used oral contraceptive pills briefly in her 20s but stopped after marriage. * **Sexual Activity**: Sexually active, monogamous relationship for 30 years, no concerns about contraception.   · **Obstetric History**:   * · **Gravida/Para**: G2P2 (2 pregnancies, 2 live births). * **Pregnancies**:   + First pregnancy: Full-term delivery, uncomplicated vaginal birth at age 25.   + Second pregnancy: Full-term delivery, uncomplicated vaginal birth at age 35. * **Miscarriages**: None reported.   · **Gynecologic History**:   * · **Pap Smears**: Last Pap smear was 2 years ago, results were normal. * **Breast Exam**: No known history of abnormal findings, has regular self-breast exams. * **Pelvic Exam**: Routine pelvic exams have been conducted annually with no abnormalities noted.   · **Menopausal History**:   * · **Menopause**: No significant symptoms of menopause yet. No hot flashes, night sweats, or vaginal dryness. * **Perimenopause**: Not currently experiencing any significant changes, regular cycles continue.   · **Gynecologic Concerns**:   * · No history of fibroids, endometriosis, or other gynecological conditions. * **Sexual Health**: No issues with sexual function, libido is stable, and sexual activity is without discomfort. |

**Family Medical History: (fill in any relevant fields)**

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| **List all relevant and appropriate family members and their age and health status, or age at and cause of death** | · **Father**:   * · **Age at Death**: 65 years old * **Cause of Death**: Complications from Type 2 diabetes (heart disease, kidney failure) * **Relevant Medical History**: Diagnosed with Type 2 diabetes at age 50, had hypertension, suffered a stroke at age 60, and had several hospitalizations for heart-related issues before passing away.   · **Mother**:   * · **Age**: 78 years old * **Health Status**: Healthy, no significant medical conditions. Active, no chronic illnesses.   · **Siblings**:   * · **Sister**:   + **Age**: 50 years old   + **Health Status**: Healthy, no known chronic conditions or serious health issues.   + **Relevant Health History**: No known health conditions, does not have diabetes.   · **Paternal Grandfather**:   * · **Age at Death**: 72 years old * **Cause of Death**: Heart attack (had a history of high blood pressure).   · **Paternal Grandmother**:   * · **Age at Death**: 68 years old * **Cause of Death**: Stroke * **Relevant Health History**: Hypertension.   · **Maternal Grandfather**:   * · **Age at Death**: 80 years old * **Cause of Death**: Prostate cancer. * **Relevant Health History**: Diagnosed with prostate cancer at age 70, lived 10 more years before passing away.   · **Maternal Grandmother**:   * · **Age**: 85 years old * **Health Status**: Alive, well, no significant health concerns. |
| **Instructions for SP on how to answer questions about any family members not listed above:**  **(i.e. do not add any additional family members, any other family is alive and well, unsure about paternal grandparents, etc.)** | Do **not** add any additional family members unless specifically prompted. If asked about family members not mentioned in the script, respond with:   * “I’m not sure about my paternal grandparents; I don’t have much information on them.” * “I don’t have any other siblings apart from my sister.” * “I don’t know much about my maternal grandparents’ health history beyond what I’ve shared.” |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Father's Diabetes**: Managed with insulin and oral medications, but he struggled with managing his blood sugar levels, which contributed to complications like heart disease, kidney failure, and stroke.  · **Mother's Health**: No chronic diseases to report; maintains a healthy lifestyle with regular exercise and a balanced diet.  · **Sister's Health**: No chronic conditions; she follows a healthy diet and exercise regimen and has regular check-ups. |

**Social History: (fill in any relevant fields)**

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| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | No recreational or illicit drug use. |
| **Tobacco Use** | No history of tobacco use. |
| **Alcohol Use** | Occasionally, 1-2 drinks per week. |
| **Home Environment** | **Home type** | Single-family house, one story. |
| **Home Location** | Suburban neighborhood, quiet area, close to parks and grocery stores. |
| **Co-habitants** | Lives alone. Her two children are grown and live in different cities. |
| **Home Healthcare devices (for virtual simulations)** | Blood pressure cuff, glucose monitor (for self-monitoring of blood sugar), and occasional use of a nebulizer for asthma. | |
| **Social Supports** | **Family & Friends** | · Sarah is close to her sister, who lives nearby and visits frequently.  · She has a few close friends in her neighborhood, but her children live in different cities and visit only occasionally. |
| **Financial** | Middle-income bracket. Sarah has a stable income from her job but lives on a tight budget. No significant financial struggles but has concerns about future medical expenses due to her diabetes. |
| **Health care access and insurance** | Has insurance through her employer. Access to healthcare is adequate; she sees her primary care physician regularly but sometimes struggles to afford all the medications and tests. |
| **Religious or Community Groups** | Active member of a local church. She volunteers occasionally and attends weekly services, which provide her with a strong sense of community. |
| **Education and Occupation** | **Level of Education** | High school graduate, attended some community college courses but never completed a degree. |
| **Occupation** | Administrative assistant at a local law firm, working part-time for the past 5 years. She’s been in her role for 10 years. |
| **Health Literacy** | Generally good understanding of her health and medications but struggles with some medical jargon. She often asks her doctor to explain things more clearly. Uses online resources for diabetes management and lifestyle tips. |
| **Sexual History:** | **Relationship Status** | Divorced, has been single for the past 10 years. |
| **Current sexual partners** | None. |
| **Lifetime sexual partners** | Married once, has had 2 partners in total. |
| **Safety in relationship** | **NA** |
| **Sexual orientation** | Heterosexual. |
| **Gender identity** | **Pronouns** | She/Her. |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | Cisgender woman. |
| **Sex assigned at birth** | Female |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | Dresses in a casual, feminine style. Typically wears comfortable clothes, often jeans and blouses. No specific signs of gender non-conformity. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | Enjoys reading, gardening, and walking in the park. Has recently started painting as a new hobby. |
| **Recent travel** | Took a short trip to visit her daughter in another state 6 months ago. No other recent travel. |
| **Diet** | **Typical day’s meals** | · Breakfast: Oatmeal with fruit, black coffee.  · Lunch: Salad with grilled chicken and olive oil dressing.  · Dinner: Grilled fish or chicken, with vegetables and a small portion of rice or quinoa. |
| **Recent meals** | Ate a fast food burger last week (rare indulgence). |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | Fried foods, red meat (for health reasons), processed snacks. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | Follows a low-carb, moderate-protein diet due to her diabetes. |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | Walks 30 minutes every day in the neighborhood. Recently joined a weekly yoga class. |
| **Recent changes to exercise/activity (and reason for change)** | Has been more active recently after her doctor encouraged her to lose weight to help control blood sugar. Previously was sedentary for several years. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | · **Pattern**: Sleeps 7-8 hours per night.  · **Quality**: Generally sleeps well, but occasionally wakes up due to stress or needing to use the bathroom at night.  · **Recent Changes**: No major changes to sleep habits. |
| **Stressors** | **Work** | Stress from her job due to workload and trying to manage her diabetes while working. The part-time role is somewhat stressful as it involves balancing administrative duties for several lawyers. |
| **Home** | Concern over maintaining her home by herself as she ages. No major issues at the moment, but she occasionally worries about needing help with housework or living alone long-term. |
| **Financial** | Stress about managing medical expenses for her diabetes care, especially since she has to pay out of pocket for some medications. Recent increases in insurance premiums have added financial strain. |
| **Other** | Worries about her health and potential complications from diabetes. Her father’s death due to complications from diabetes is a constant reminder of the importance of managing her condition effectively. |

**Physical Exam Findings: (may also include instructions on simulating/replicating/reporting findings, e.g., physical simulations, verbal prompts, findings cards, moulage, hybrid technology)**

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| · **General Appearance**: Overweight, appears tired but alert.  · **Vital Signs**:   * Blood pressure: 145/90 mmHg * Heart rate: 88 bpm * Respiratory rate: 18 breaths/min * Temperature: 98.4°F (37°C) * Oxygen saturation: 98% on room air   · **Cardiovascular**: Regular rate and rhythm, no murmurs.  · **Respiratory**: Clear to auscultation bilaterally.  · **Abdomen**: Soft, non-tender, no hepatomegaly or splenomegaly.  · **Neurological**: Alert and oriented x3, normal reflexes.  · **Musculoskeletal**: No joint tenderness or swelling.  · **Skin**: No rashes, but skin appears somewhat dry. |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | · Could this be diabetes? I’m really worried about that because my father had it and passed away from complications.”  · “I don’t really know what I should be eating or how to manage this if it is diabetes. Could you help with that?” |
| **Questions the SP will ask if given the opportunity** | · **About Her Diabetes**:   * · "Is there anything I can do to better manage my blood sugar levels? I feel like I’m doing okay, but I’m worried about complications down the road." * "Do you think I need to adjust my medications or make any changes to my diet to help control my diabetes better?" * "I've heard that some people with diabetes can have issues with their feet or kidneys. Should I be getting checked for that regularly?"   · **About Weight Management**:   * · "I’ve been trying to lose a little weight to help with my blood sugar. Is there a specific weight range I should aim for, or do you think I'm on the right track?" * "Can you recommend any specific exercises or routines that would help me with weight loss while managing my diabetes?"   · **About Health Monitoring**:   * · "How often should I be checking my blood sugar at home? Is there a certain range I should be aiming for?" * "Should I be tracking anything else besides my blood sugar, like my blood pressure or cholesterol?"   · **About Preventative Care**:   * · "Should I get tested for any complications, like nerve damage or eye problems? I’m not sure what tests I should be having." * "Would a referral to a dietitian or diabetes educator be helpful for me to get some additional support?"   · **About Managing Stress**:   * · "I feel like I’ve been under a lot of stress lately. Could this affect my blood sugar? What are some strategies for managing stress better?"   · **About Medication**:   * · "I'm on a few medications right now—should I be worried about any interactions with my diabetes medications?" * "Could the medication I’m taking for my blood pressure be affecting my diabetes, or should we be concerned about that?"   · **About Future Health**:   * · "My father had complications from diabetes. How can I make sure I don’t face the same health problems he did? Are there preventative steps I should be taking?" * "I’m getting older, and I’m concerned about my long-term health. Is there anything I should do now to help reduce my risk of complications in the future?"   · **About the Impact of Diabetes on Daily Life**:   * · "Is there anything I should be doing differently in my daily routine to help manage my diabetes, especially as I get older?" * "I’ve been feeling more tired than usual lately. Could this be related to my diabetes, or is something else going on?" |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | · Diagnosis of Type 2 Diabetes Mellitus, plan for testing (e.g., blood glucose, A1C), education on diet and lifestyle changes, and possibly medication.  · Reassurance, with a plan to address her concerns and educate her on managing the condition. |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | * The patient may be unaware of the results of any previous tests or her current A1C level. |