Standardized Patient Form

|  |  |
| --- | --- |
| ***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:** Ms. Lin Zhang

**Age: 35**

**Gender:** Female

**Chief Complaint:** "I have been feeling very anxious, hot all the time, and losing weight despite eating normally."

**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***

|  |
| --- |
| · **Affect:** Anxious, restless, cooperative but somewhat agitated.  · **Speech:** Fast-paced, sometimes seems to be talking more than expected due to nervousness.  · **Body language:** Fidgeting, occasional shaking of hands, tapping feet.  · **Non-verbal Communication:** Sweating slightly, frequently adjusting clothing due to feeling hot, avoids direct eye contact at times due to anxiety.  · **Changes as Case Progresses:** As more symptoms are explored, the patient may become more focused on discussing recent weight loss and increased anxiety. The anxiety level may also fluctuate, especially when asked about family history or other medical concerns. |

**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.*

|  |  |
| --- | --- |
| **Opening Statement(s)** | "I’ve been feeling very anxious and nervous lately. I’m always hot, even when others feel comfortable. I've lost a lot of weight without trying. I have trouble sleeping, and I feel a little shaky sometimes. I just don’t feel like myself." |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · "I’ve noticed my heart racing a lot more than usual, especially when I’m resting."  · "I’ve been feeling exhausted despite sleeping a lot, but I still can’t sleep well."  · "I don’t know why, but I’ve been feeling really irritable too. I just get upset really easily. |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · "I’ve had this feeling for about three months now, and it seems to be getting worse."  · "I’ve been losing about 10 pounds in the last two months without changing my diet or exercise habits."  · "I’ve had more trouble swallowing, but it’s not painful. Just feels like there’s a lump in my throat." |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | · **Family History of Thyroid Disease:** Ms. Zhang does not initially mention that her mother was diagnosed with hyperthyroidism in her 50s.  · **Stress:** Ms. Zhang doesn't mention a recent stressful event unless specifically asked about life changes. |

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

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

|  |  |
| --- | --- |
| **Quality/Character** | Anxiety, heat intolerance, weight loss, fatigue, occasional hand tremors. |
| **Onset** | Symptoms began around 3 months ago. |
| **Duration/Frequency** | Continuous symptoms, with increasing severity over the past month. |
| **Location** | No specific location, but general discomfort and heat intolerance. |
| **Radiation** | No radiation of symptoms, though heart palpitations seem more noticeable when anxious. |
| **Intensity (e.g. 1-10 scale for pain)** | "The palpitations feel very strong sometimes, like my heart is beating out of my chest." |
| **Treatment (what has been tried, what were the results)** | No treatment attempted yet. |
| **Aggravating** **Factors (what makes it worse)** | Stress or physical activity seems to make symptoms worse. |
| **Alleviating** **Factors (what makes it better)** | Rest doesn’t seem to help much, though some relief is experienced in cooler environments. |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | No obvious precipitating factors. |
| **Associated** **Symptoms** | Weight loss (10 lbs over 2 months), heat intolerance, fatigue, irritability, palpitations, tremors. |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | Ms. Zhang is concerned about her unintentional weight loss and how it affects her health and well-being, especially since she is normally quite healthy and active. |

**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)**

|  |
| --- |
| · **Constitutional:** Unexplained weight loss, fatigue, night sweats.  · **Skin:** Warm, moist skin, slight tremors in hands.  · **HEENT:** No significant vision changes, no eye irritation or dryness, but occasional blurred vision.  · **Endocrine:** Increased thirst, excessive sweating.  · **Respiratory:** No shortness of breath, but feels out of breath after mild exertion.  · **Cardiovascular:** Palpitations, rapid heart rate, occasional chest discomfort.  · **Gastrointestinal:** No nausea, but occasional mild constipation.  · **Urinary:** Normal, no changes.  · **Musculoskeletal:** Mild weakness in arms and legs, particularly when lifting.  · **Neurologic:** Hand tremors, difficulty concentrating.  · **Psychiatric/Behavioral:** Anxiety, irritability, difficulty relaxing or sleeping. |

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

|  |  |
| --- | --- |
| **Illnesses/Injuries (chronic or otherwise relevant)** | Generally healthy, no chronic illnesses. |
| **Hospitalizations** | **None** |
| **Surgical History** | No surgeries |
| **Screening/Preventive (including vaccinations /immunizations)** | Regular health check-ups, no known issues with thyroid in the past. |
| **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** | No prescription medications; occasional over-the-counter pain relievers for headaches. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | No known allergies. |
| **Gynecologic History** | **Menstrual History:**  * **Menarche:** Age 13 * **Cycle Regularity:** Regular cycles every 28-30 days * **Menstrual Duration:** 5-7 days * **Flow:** Moderate to heavy flow with no abnormal clots * **Dysmenorrhea (Painful Periods):** Occasional mild cramps, relieved by over-the-counter medications * **Last Menstrual Period (LMP):** 1 week ago * **Menstrual Irregularities:** None noted in the past  **Contraceptive History:**  * **Current Contraception:** None (patient is not currently using birth control) * **Past Contraception:** Oral contraceptive pills for 5 years, stopped 6 months ago when trying to conceive. No other methods used.  **Obstetric History:**  * **Gravida:** 2 * **Para:** 2 (2 live births) * **Pregnancies:** Both pregnancies were full-term with no complications. * **Deliveries:** Both vaginal deliveries without complications, no history of C-sections or preterm births. * **Miscarriages/Abortions:** None. * **Ectopic Pregnancy:** No history of ectopic pregnancy.  **Gynecological Procedures:**  * **Pap Smear:** Last pap smear was 2 years ago, results were normal. * **Pelvic Exam:** No history of abnormal findings or interventions. * **Surgeries:** None.  **Sexual History:**  * **Sexual Activity:** Sexually active with her husband for 8 years, no issues with sexual activity. * **Sexual Orientation:** Heterosexual * **Contraceptive Use:** No contraception used since stopping birth control 6 months ago; not actively trying to conceive but would like children in the future. * **History of STIs:** No history of sexually transmitted infections. * **Current Partner(s):** Monogamous relationship with husband. * **Sexual Dysfunction:** No issues with libido or pain during intercourse.  **Gynecologic Symptoms:**  * **Pelvic Pain:** No pelvic pain or discomfort. * **Vaginal Discharge:** No abnormal vaginal discharge; normal consistency and color. * **Urinary Symptoms:** No incontinence, dysuria, or frequency. * **Menopausal Symptoms:** No signs of perimenopause or menopause (no hot flashes, irregular periods, etc.).  **Family History (Gynecologic):**  * **Mother:** No history of breast cancer, ovarian cancer, or uterine cancer. * **Sisters:** No known gynecologic conditions or cancers. * **Grandmother (maternal):** History of uterine fibroids, no history of cancer. |

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

|  |  |
| --- | --- |
| **List all relevant and appropriate family members and their age and health status, or age at and cause of death** | · **Father:** Age 58, alive, healthy, no chronic illnesses reported.  · **Mother:** Age 56, alive, diagnosed with hypertension 5 years ago, managed with medication. No history of thyroid disease, diabetes, or cancer.  · **Paternal Grandfather:** Deceased at age 82, cause of death: heart attack. History of hypertension and hyperlipidemia.  · **Paternal Grandmother:** Deceased at age 78, cause of death: stroke. No known thyroid issues.  · **Maternal Grandfather:** Deceased at age 72, cause of death: cancer (lung cancer).  · **Maternal Grandmother:** Age 79, alive, diagnosed with osteoarthritis, otherwise in good health.  · **Siblings:**   * **Brother:** Age 30, healthy, no chronic diseases or conditions. * **Sister:** Age 34, healthy, no chronic diseases or conditions.   · **Children:**   * **Son:** Age 5, healthy, no medical concerns. * **Daughter:** Age 3, healthy, no medical 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.)** | * **Paternal Grandparents:** Patient is unsure of the exact health status of paternal grandparents. If asked about them, answer that the patient is not sure about the details, but they were generally described as healthy in their later years. * **Maternal Grandparents:** Both maternal grandparents are alive, but the patient only knows about the grandmother’s current health status (osteoarthritis) and the grandfather’s death from cancer. Do not provide additional health details about maternal grandparents unless asked directly. * **Other Family Members:** Patient does not have additional family members to report beyond the listed immediate family. If asked about extended family, clarify that the patient does not have detailed information. |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Mother's Hypertension:** Managed with medication (Lisinopril), controlled with no known complications.  · **Paternal Grandfather's Hypertension and Hyperlipidemia:** Managed with lifestyle changes (diet and exercise), medication (statins for hyperlipidemia), and blood pressure medications. No specific mention of complications.  · **Maternal Grandfather's Cancer:** Diagnosed late in life, managed with chemotherapy, but passed away within a year of diagnosis.  · **Maternal Grandmother's Osteoarthritis:** Managed with over-the-counter pain relief (acetaminophen), no major surgeries or treatments reported |

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

|  |  |  |
| --- | --- | --- |
| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | No drug use, occasionally drinks alcohol (1-2 drinks a week). |
| **Tobacco Use** | Non-smoker. |
| **Alcohol Use** | Occasional social drinking. |
| **Home Environment** | **Home type** | Apartment in a residential complex, 3rd floor with no elevator |
| **Home Location** | Urban area, central part of the city, near public transportation (bus and subway stations within walking distance) |
| **Co-habitants** | Lives with husband (age 32, healthy), son (age 5), and daughter (age 3) |
| **Home Healthcare devices (for virtual simulations)** | None, no special healthcare devices used in the home environment at this time. | |
| **Social Supports** | **Family & Friends** | * · **Family Support:** Close relationship with immediate family (mother and sister), speaks to mother weekly and sister every other week. * **Friends:** Good social circle, stays in touch with a few close friends from college, but no frequent gatherings due to time constraints. * **Emotional Support:** Mainly from husband, who is supportive but busy with work. Has a few friends that offer emotional support but doesn’t rely on them frequently. |
| **Financial** | · **Household Income:** Middle-income household, both she and her husband work, but budgeting is important for managing family expenses.  · **Insurance:** Health insurance through her husband’s employer, covers most basic health needs. Occasionally, they have out-of-pocket expenses for children’s medical needs and non-urgent services.  · **Financial Stress:** Some stress due to balancing work, children’s daycare costs, and saving for future expenses like children’s education. No major financial crises currently. |
| **Health care access and insurance** | · **Access to Care:** The patient has access to healthcare through a public health insurance plan provided by her husband's employer. No major issues with healthcare access.  · **Current Health Insurance Coverage:** Covers basic medical needs, including general visits, lab tests, and some specialty care. Coverage is good but has co-pays for some services. |
| **Religious or Community Groups** | · **Religion:** Not very religious, but identifies as culturally Christian and participates in church activities on major holidays.  · **Community Groups:** Active in a local parenting support group that meets once a month. |
| **Education and Occupation** | **Level of Education** | Bachelor’s degree in business administration |
| **Occupation** | Works as an office manager at a local marketing firm, full-time, 9 AM to 5 PM. |
| **Health Literacy** | High health literacy, understands basic medical concepts, and actively seeks information online about her health and her children’s health. She can navigate medical websites and ask informed questions during doctor visits. |
| **Sexual History:** | **Relationship Status** | Married to her husband for 8 year |
| **Current sexual partners** | One (husband), monogamous relationship. |
| **Lifetime sexual partners** | One (husband). |
| **Safety in relationship** | No issues or concerns about safety in the relationship. The relationship is stable, and she feels safe and supported. |
| **Sexual orientation** | Heterosexual |
| **Gender identity** | **Pronouns** | She/Her/Hers |
| **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)** | Typically dresses in a feminine style, with a preference for casual and comfortable clothing. Body language is relaxed, and there are no indications of gender nonconformity. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · Enjoys reading (fiction and self-improvement books), cooking, and spending time with her family.  · Occasionally participates in DIY home improvement projects, gardening, and crafting.  · Enjoys walking in the park with her children on weekends. |
| **Recent travel** | **Recent Travel:**   * Went on a family vacation to the beach 3 months ago. * No upcoming travel plans, but hoping to take a weekend trip with her husband in the coming months. |
| **Diet** | **Typical day’s meals** | · **Breakfast:** Oatmeal with fruit, coffee  · **Lunch:** Sandwich (turkey, lettuce, tomato, and whole grain bread) with an apple  · **Dinner:** Chicken or fish, steamed vegetables, brown rice or quinoa  · **Snacks:** Nuts, yogurt, or fruit  · **Water Intake:** 4-5 cups of water a day |
| **Recent meals** | · Last night had stir-fried chicken with vegetables and rice.  · For lunch today, had a salad with mixed greens, chicken breast, and vinaigrette dressing. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | · Avoids fried foods, fast food, and heavy, greasy meals.  · Tries to limit sugary foods and drinks. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | No specific diet restrictions. Occasionally follows a more plant-based meal plan when she feels it is healthier, but it’s not consistent. |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Exercise Activities and Frequency:**   * Walks for about 30 minutes 3-4 times a week after work. * Occasionally does home yoga sessions for relaxation (1-2 times a week). * Prefers low-impact exercises due to some back discomfort. |
| **Recent changes to exercise/activity (and reason for change)** | **Recent Changes to Exercise/Activity:**   * Recently began walking more after experiencing mild fatigue and noticing weight gain. Wants to be more active to improve overall health and energy levels. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | * **Pattern:** Typically goes to bed around 11 PM and wakes up at 6:30 AM to get the children ready for school. * **Length:** 6-7 hours per night, though she would prefer more sleep. * **Quality:** Sleep quality is fair, with occasional disruptions due to the children waking up at night or stress from work. * **Recent Changes:** No major changes, though she feels slightly more fatigued than usual in recent weeks due to increased work and family commitments. |
| **Stressors** | **Work** | · Balancing a full-time job with managing household responsibilities and taking care of the children.  · Increased work pressure recently as her company is going through some changes. |
| **Home** | · Juggling parenting with housework and personal time.  · Concerned about keeping up with household chores while managing her health. |
| **Financial** | Mild stress about budgeting for long-term expenses (children's education, healthcare costs). |
| **Other** | Feels a bit overwhelmed by the demands of her daily life but is actively working to balance work, family, and personal well-being. |

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

|  |
| --- |
| **General Appearance:** Mildly anxious, appears slightly underweight (approximately 10 lbs lost in 2 months), flushed, and sweaty.  **Vital Signs:**   * + Temperature: 99.6°F (37.5°C)   + Heart rate: 110 bpm, regular   + Blood pressure: 130/85 mmHg   + Respiratory rate: 18 breaths per minute   + Weight: 115 lbs (50 kg), down from 125 lbs (56.7 kg) 2 months ago.   **Head, Eyes, Ears, Nose, Throat (HEENT):**   * + Eyes: Mild exophthalmos (bulging eyes), no conjunctival injection.   + Neck: Mildly enlarged thyroid gland, no tenderness or palpable nodules.   **Cardiovascular:**   * + Tachycardia (HR: 110 bpm), regular rhythm, no murmurs or gallops.   + Mild tremor in hands.   **Respiratory:** Normal breath sounds, no wheezing or crackles.  **Abdomen:** Soft, non-tender, no hepatomegaly or splenomegaly.  **Musculoskeletal:** No joint pain, mild muscle weakness in upper limbs, slight tremor in hands. |

**Prompts and Special Instructions:**

|  |  |
| --- | --- |
| **Questions the SP MUST ask/ Statements patient must make** | · "I’ve been feeling really anxious and I can't relax."  · "I’ve lost weight without trying."  · "I’ve been feeling hot all the time, even when others say it’s cool."  · "I have trouble sleeping but I feel exhausted all the time." |
| **Questions the SP will ask if given the opportunity** | · "Could something be wrong with my thyroid?"  · "What could be causing these symptoms?" |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | · Diagnosis of hyperthyroidism, with possible recommendations for thyroid function tests (TSH, T3, T4).  · Discussion of treatment options, including antithyroid medications, potential lifestyle changes, and follow-up. |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | Learner may have access to prior lab results suggesting hyperthyroidism or may know about potential tests to order based on the patient's presentation. |