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**: Mary Johnson

· **Age**: 45

· **Gender**: Female

· **Chief Complaint**: "I have been having pain in my upper abdomen for the past few days, and it’s been getting worse."

**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, somewhat distressed due to the pain but still cooperative.  · **Speech**: Clear but occasionally interrupted by pain; responds to questions with a moderate pace.  · **Body Language**: May place hand on the right upper abdomen to signify pain, shifts posture frequently due to discomfort.  · **Non-verbal communication**: Frequent sighs, occasional grimace, may lean forward to ease discomfort. |

**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 this discomfort in my upper stomach for a few days. At first, it wasn’t too bad, but now the pain is worse and feels like it’s spreading to my back. I haven’t been able to keep food down." |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · "I’ve also been feeling nauseous and sometimes I get chills."  · "I’m worried it could be something serious, I’ve heard of gallstones before." |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · "The pain started out as a dull ache, but now it comes in sharp waves, especially after eating. It seems to be worse after I eat fatty foods."  · "It feels like the pain is in the upper right part of my stomach, but sometimes it radiates to my back or shoulder."  · "I’ve had episodes like this before, but they’ve never lasted this long."  · "I don’t usually have any problems with digestion, but now I’m avoiding eating because of the pain." |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | * "I don’t usually have any other medical issues, but I’m not sure if I’ve ever been checked for gallstones before." * "I have had some heartburn or indigestion in the past, but this feels different." |

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

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

|  |  |
| --- | --- |
| **Quality/Character** | Sharp, cramp-like pain, intermittently severe. |
| **Onset** | Started a few days ago, gradually worsening. |
| **Duration/Frequency** | Pain comes in waves, lasting anywhere from 30 minutes to 2 hours. |
| **Location** | Upper right abdomen. |
| **Radiation** | Pain sometimes radiates to the back and right shoulder blade. |
| **Intensity (e.g. 1-10 scale for pain)** | 7/10 at its worst, fluctuating depending on food intake and activity. |
| **Treatment (what has been tried, what were the results)** | Has taken over-the-counter antacids, but they provide little relief. |
| **Aggravating** **Factors (what makes it worse)** | Eating fatty foods, large meals. |
| **Alleviating** **Factors (what makes it better)** | Lying down, avoiding food. |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | Eating greasy or fried foods seems to trigger the pain. |
| **Associated** **Symptoms** | Nausea, occasional chills, and feeling bloated after meals. |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | The patient is worried the pain might be related to gallstones or another serious condition. The pain is interfering with her ability to eat normally and is causing significant stress. |

**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**: No fever or significant weight loss. * **Skin**: No rashes, jaundice, or changes in skin color. * **HEENT**: No headaches, vision changes, or sore throat. * **Endocrine**: No history of thyroid problems or diabetes. * **Respiratory**: No cough, shortness of breath, or wheezing. * **Cardiovascular**: No chest pain, palpitations, or swelling in the legs. * **Gastrointestinal**: Pain localized to upper abdomen, occasional nausea, and bloating. No diarrhea or constipation. * **Urinary**: No changes in urination or blood in the urine. * **Reproductive**: No concerns, regular menstrual cycle. * **Musculoskeletal**: No joint pain, muscle aches, or back pain unrelated to the abdominal symptoms. * **Neurologic**: No headaches, dizziness, or tingling. * **Psychiatric/Behavioral**: Mild anxiety related to the pain and concerns about her health. |

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

|  |  |
| --- | --- |
| **Illnesses/Injuries (chronic or otherwise relevant)** | No significant past medical history. |
| **Hospitalizations** | None. |
| **Surgical History** | None. |
| **Screening/Preventive (including vaccinations /immunizations)** | Regular screenings, including mammograms, but no specific screening for gallstones. |
| **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** | Antacids (Tums) as needed for indigestion. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | No known allergies. |
| **Gynecologic History** | · **Menstrual History**:   * · **Age at menarche**: 12 years old. * **Cycle Regularity**: Regular cycles, 28-30 days in length. * **Menstrual Flow**: Moderate flow lasting 4-5 days. * **Last Menstrual Period**: 2 weeks ago. * **Painful Periods**: Occasionally mild cramping, but not severe enough to interfere with daily activities.   · **Contraception**:   * · **Current Method**: None. She is not currently using any form of contraception. * **Past Contraception**: Used oral contraceptives in her 20s, but stopped due to side effects (headaches and nausea). * **Sexual Activity**: Active with her husband, in a monogamous relationship for over 10 years.   · **Pregnancy History**:   * · **Number of Pregnancies**: 2 (both full-term, vaginal deliveries). * **Gravida/Para**: G2P2 (2 pregnancies, 2 live births). * **Complications**: No complications during pregnancy, deliveries were uncomplicated.   · **Menopause**:   * · **Perimenopausal Symptoms**: No significant symptoms of menopause at present. No hot flashes, irregular periods, or mood swings reported. * **Menopause Status**: Pre-menopausal, no history of hysterectomy or oophorectomy.   · **Gynecologic Conditions**:   * · No history of endometriosis, fibroids, or ovarian cysts. * No history of pelvic inflammatory disease (PID) or sexually transmitted infections (STIs). * Pap smear: Last screening done 18 months ago; results were normal.   · **Other**:   * · No history of abnormal vaginal bleeding, discharge, or itching. * No history of urinary incontinence, pelvic pain unrelated to abdominal issues. |

**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**: 70 years old. * **Health Status**: Hypertension, history of gallstones (managed with diet and medication). No history of heart disease or diabetes. * **Cause of Death**: Alive, no significant health issues beyond hypertension.   · **Mother**:   * · **Age**: 68 years old. * **Health Status**: Generally healthy, no known chronic illnesses. She has no history of gallbladder issues or major medical conditions. * **Cause of Death**: Alive, no significant health problems.   · **Siblings**:   * · **Older Brother**:   + **Age**: 50 years old.   + **Health Status**: History of gallstones, had gallbladder removed (cholecystectomy) 5 years ago due to recurrent pain and discomfort. No other chronic conditions.   + **Cause of Death**: Alive, no significant health problems post-surgery. * **Younger Sister**:   + **Age**: 42 years old.   + **Health Status**: No known chronic conditions, healthy overall. No history of gallstones.   + **Cause of Death**: Alive, no significant health concerns.   · **Paternal Grandparents**:   * · **Paternal Grandfather**: Deceased at age 75 from heart disease. * **Paternal Grandmother**: Deceased at age 80 from cancer (type not specified).   · **Maternal Grandparents**:   * · **Maternal Grandfather**: Deceased at age 82 from natural causes, no significant chronic diseases. * **Maternal Grandmother**: Deceased at age 80 from cancer (type not specified). |
| **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 beyond those mentioned above.  · **Response Example**: "I’m not sure about my paternal grandparents' health history. My father’s side is a bit distant, but my maternal family is healthy overall. I’m not aware of any significant health problems in my family beyond what I’ve shared." |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Father’s Hypertension**: Managed with medication (ACE inhibitors), follows a low-sodium diet.  · **Brother's Gallstones**: Managed by surgical removal of gallbladder after recurrent pain, no long-term complications post-surgery. |

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

|  |  |  |
| --- | --- | --- |
| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | No recreational drug use. |
| **Tobacco Use** | No smoking. |
| **Alcohol Use** | · Drinks socially, about 1-2 drinks per week. |
| **Home Environment** | **Home type** | Single-family home, two-story house with a backyard. |
| **Home Location** | Suburban area, quiet neighborhood, near a local park and grocery store. |
| **Co-habitants** | Lives with her husband and two children (ages 8 and 10). No other individuals live in the household. |
| **Home Healthcare devices (for virtual simulations)** | None. No specific medical devices are used in the home for virtual simulations. | |
| **Social Supports** | **Family & Friends** | · **Family**: Close-knit family. Regular contact with parents (who live nearby) and a younger sibling who lives in a different city.  · **Friends**: A group of close friends from college and a few work colleagues. Regularly socializes with them. |
| **Financial** | Stable financial situation, both she and her husband work full-time jobs. They have a mortgage on their house but manage the payments without difficulty. |
| **Health care access and insurance** | · **Health Insurance**: Covered through her husband's employer's insurance plan.  · **Healthcare Access**: Excellent access to healthcare, with a local primary care physician and access to specialists if needed. |
| **Religious or Community Groups** | Not particularly religious, but participates in community events and is active in a local moms' group that organizes activities for children and families. |
| **Education and Occupation** | **Level of Education** | Bachelor's degree in business administration. |
| **Occupation** | Works as a project manager for a medium-sized tech company. Full-time, office-based job. |
| **Health Literacy** | High health literacy. Has a solid understanding of basic health concepts, and is comfortable navigating healthcare information, though not a healthcare professional. |
| **Sexual History:** | **Relationship Status** | Married for 10 years. |
| **Current sexual partners** | One partner—her husband. |
| **Lifetime sexual partners** | No other sexual partners besides her husband. |
| **Safety in relationship** | The relationship is healthy and safe, no concerns about abuse or violence. |
| **Sexual orientation** | Heterosexual. |
| **Gender identity** | **Pronouns** | She/Her/Hers. |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | Female, identifies as cisgender. |
| **Sex assigned at birth** | Female. |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | Typically dresses in feminine clothing, business casual for work, and casual attire at home. Appears in a traditionally feminine presentation. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · Enjoys reading, cooking, and spending time with her children. Loves outdoor activities like hiking and gardening.  · Recently started attending a yoga class once a week to help with stress management. |
| **Recent travel** | Took a family vacation to a nearby beach destination last summer. No international travel recently. |
| **Diet** | **Typical day’s meals** | · Breakfast: Coffee, a smoothie with fruits, spinach, and protein powder.  · Lunch: Salad with grilled chicken, vegetables, and a vinaigrette dressing.  · Dinner: Grilled fish or chicken with a side of vegetables or quinoa. Occasionally, pasta with marinara sauce. |
| **Recent meals** | * · Had sushi for dinner two nights ago. * Ate homemade vegetable stir fry with brown rice last night. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | Tries to limit fried foods, fast food, and foods with high sugar content. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | Follows a balanced, moderately low-carb diet. Avoids processed foods and is mindful of eating whole foods. |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | · Attends yoga class once a week.  · Walks her dog daily, about 30 minutes per day.  · Occasionally participates in a 5k charity walk/run in the spring and fall. |
| **Recent changes to exercise/activity (and reason for change)** | Has recently increased walking frequency to 5-6 days a week after feeling more stress due to work and family obligations. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | · Typically goes to bed around 11:00 PM and wakes up around 6:30 AM.  · Sleep quality is generally good, though she occasionally struggles to fall asleep if she is particularly stressed.  · Recently noticed feeling more tired during the day, likely due to increased work stress. |
| **Stressors** | **Work** | Increasing work demands, with several high-priority projects overlapping. Recently promoted to a higher managerial role, which comes with more responsibility and pressure. |
| **Home** | Balancing her work and home life, especially managing her children’s school schedules, extracurricular activities, and household duties. |
| **Financial** | No major financial stress, but concerned about future college expenses for her children. |
| **Other** | Worries about her health and managing her weight as she gets older. Recently noticed some digestive issues that are concerning her, though she has not yet seen a doctor for them. |

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

|  |
| --- |
| · **General**: Appears mildly distressed, but alert and oriented. No signs of acute distress.  · **Abdominal**:   * Tenderness on palpation of the upper right quadrant. * No palpable masses. * Positive Murphy’s sign (pain upon deep inspiration with palpation of the right upper quadrant). * No guarding or rebound tenderness.   · **Other Systems**: Normal exam for the rest of the systems. |

**Prompts and Special Instructions:**

|  |  |
| --- | --- |
| **Questions the SP MUST ask/ Statements patient must make** | * "Does this pain sound like anything you’ve encountered before, doctor?" * "I’m worried it might be gallstones, do you think it could be?" * "What kind of tests do you think are necessary?" |
| **Questions the SP will ask if given the opportunity** | · "What tests should be done to confirm what’s going on?"  · "Should I be worried about the pain getting worse?" |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | · Diagnosis: Likely gallstones (cholelithiasis), possibly with biliary colic or mild cholecystitis.  · Plan: Likely recommendation for imaging (ultrasound), and possible referral to surgery for gallbladder removal if the diagnosis is confirmed.  · Treatment: Depending on the diagnosis, could include conservative management (e.g., diet changes) or surgery.  · Reassurance: The patient should be reassured that the condition is treatable, and proper management will help alleviate symptoms. |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | The learner should reach the correct diagnosis, explain the possible causes of the symptoms (gallstones, possible complications), and provide a plan for imaging (usually an ultrasound) and potential referral for treatment. |