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:** John Doe

**Age:** 45

**Gender:** Male

**Chief Complaint:** "I have a lump in my groin that’s been hurting for the last few weeks."

**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:** Generally calm but with some discomfort when discussing the pain. * **Speech:** Short and direct; occasionally pauses to reflect on symptoms. * **Body Language:** Frequently touches the groin area, especially when discussing pain. * **Non-Verbal Communication:** Shifts slightly uncomfortably while sitting. May hold the groin area if the pain increases. Looks a bit worried when describing symptoms. |

**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 noticing a lump in my groin for a couple of weeks. It’s kind of painful at times, especially when I bend over or lift something heavy."  · "I’ve had some discomfort in the area, but I didn’t think much of it until it started to hurt more recently." |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · "It started out small, but over time the lump has gotten a little bigger."  · "I’m not sure if I’ve strained it, but I’ve been lifting heavy boxes at work recently."  · "The pain seems to be worse at the end of the day, especially after standing or walking for a long time." |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · "I don’t have any history of hernias in my family, but I did have an appendectomy when I was younger."  · "No nausea or vomiting, just the pain and discomfort in my groin." |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | · "I’m not sure if I’ve had any weight changes recently, but I’ve been feeling a bit more fatigued at work."  · "I’ve also had some slight discomfort during sexual activity, but I didn’t think it was important to mention." |

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

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

|  |  |
| --- | --- |
| **Quality/Character** | The lump in the groin is described as firm and non-reducible. Pain is sharp and aching, especially after physical exertion (lifting, bending). |
| **Onset** | Symptoms began 2–3 weeks ago after lifting heavy objects at work. |
| **Duration/Frequency** | The lump is constant but becomes more noticeable with activity. The pain occurs intermittently throughout the day but is worse at night. |
| **Location** | Groin area, primarily on the right side. |
| **Radiation** | No radiation of the pain. |
| **Intensity (e.g. 1-10 scale for pain)** | Pain is rated 5/10 on a scale of 1-10 at rest, increasing to 7/10 with movement or exertion. |
| **Treatment (what has been tried, what were the results)** | No formal treatment has been attempted. Over-the-counter pain medications (Ibuprofen 400mg, taken 2-3 times a day) have been used with mild relief. |
| **Aggravating** **Factors (what makes it worse)** | The pain worsens with bending, lifting, or standing for long periods. |
| **Alleviating** **Factors (what makes it better)** | Rest and lying down seem to alleviate the discomfort slightly. |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | Lifting heavy items at work, bending down, or exerting pressure on the abdomen. |
| **Associated** **Symptoms** | No nausea, vomiting, or fever. No changes in bowel or urinary habits. |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | The patient is concerned about the lump and the increasing pain. He is unsure whether he has injured himself or if this could be something more serious. |

**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, weight loss, or night sweats.  · **Skin:** No rashes or skin changes.  · **HEENT:** No headaches, vision, or hearing problems.  · **Endocrine:** No changes in appetite or thirst. No recent changes in weight.  · **Respiratory:** No shortness of breath, cough, or wheezing.  · **Cardiovascular:** No chest pain or palpitations.  · **Gastrointestinal:** No nausea, vomiting, diarrhea, or constipation. No blood in stool.  · **Urinary:** No changes in frequency, color, or discomfort during urination.  · **Reproductive:** No significant issues. No recent problems with sexual activity, although slight discomfort was noted during sex.  · **Musculoskeletal:** No joint pain or muscle weakness, but groin pain after heavy lifting.  · **Neurologic:** No dizziness, numbness, or weakness.  · **Psychiatric/Behavioral:** No anxiety or depression reported. |

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

|  |  |
| --- | --- |
| **Illnesses/Injuries (chronic or otherwise relevant)** | · History of appendectomy at age 20.  · No chronic illnesses or conditions. |
| **Hospitalizations** | Hospitalized once for the appendectomy. |
| **Surgical History** | Appendectomy, no complications. |
| **Screening/Preventive (including vaccinations /immunizations)** | · Regular health check-ups, last physical exam 1 year ago with normal results.  · Vaccinated for flu and tetanus. |
| **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** | Ibuprofen 400mg as needed for pain relief. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | No known drug allergies. |
| **Gynecologic History** | **NA** |

**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   + **Health Status:** Healthy, no known chronic conditions or illnesses.   + **Cause of Death (if applicable):** N/A   **Mother:**   * + **Age:** 68   + **Health Status:** Healthy, no known chronic conditions or illnesses.   + **Cause of Death (if applicable):** N/A   **Brother:**   * + **Age:** 42   + **Health Status:** Healthy, no chronic conditions.   **Paternal Grandfather:**   * + **Age at Death:** 80   + **Cause of Death:** Natural causes.   **Maternal Grandfather:**   * + **Age at Death:** 75   + **Cause of Death:** Heart disease.   **Paternal Grandmother:**   * + **Age at Death:** 82   + **Cause of Death:** Natural causes.   **Maternal Grandmother:**   * + **Age at Death:** 78   + **Cause of Death:** Stroke. |
| **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 introduce any additional family members unless specifically asked.  · If asked about paternal grandparents, the SP can say, "I’m not sure about the paternal grandparents’ health status, but both passed away many years ago."  · The SP should maintain consistency and only mention family members listed above in response to any direct questioning about the family. |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Father:** No known chronic conditions; no treatments required.  · **Mother:** No known chronic conditions; no treatments required.  · **Brother:** No known conditions; no treatments required.  · **Maternal Grandfather:** Managed heart disease for several years before passing at age 75. No major interventions mentioned.  · **Maternal Grandmother:** Had a stroke at age 78, but there’s no specific treatment history mentioned.  · **Paternal Grandparents:** No significant medical history is known or mentioned. |

**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** | Non-smoker. |
| **Alcohol Use** | Drinks alcohol occasionally (1-2 beers on weekends). |
| **Home Environment** | **Home type** | Single-story house, suburban neighborhood. |
| **Home Location** | Suburb, in a quiet area near a small town. |
| **Co-habitants** | Lives with his wife and two children (ages 10 and 14). |
| **Home Healthcare devices (for virtual simulations)** | None specifically mentioned, but patient may mention using over-the-counter medications (e.g., Ibuprofen) for pain relief. | |
| **Social Supports** | **Family & Friends** | · Strong family support; lives with wife and children.  · Social circle includes a few close friends from work and local community. |
| **Financial** | · No significant financial difficulties.  · Employed full-time as a warehouse manager.  · Healthcare coverage through employer-provided insurance. |
| **Health care access and insurance** | · Has private health insurance through his employer, which provides access to specialists and primary care.  · No issues accessing healthcare services. |
| **Religious or Community Groups** | · Occasionally attends a local church on Sundays but not very active in religious activities.  · Participates in neighborhood events and gatherings. |
| **Education and Occupation** | **Level of Education** | High school graduate. |
| **Occupation** | Warehouse manager for a logistics company.   * Typically requires manual labor, including heavy lifting, standing for long periods, and bending. |
| **Health Literacy** | · Generally good health literacy. Understands basic medical terms and treatments.  · Not well-versed in specialized medical terminology but comfortable asking questions when necessary. |
| **Sexual History:** | **Relationship Status** | Married, heterosexual. |
| **Current sexual partners** | One, his wife. |
| **Lifetime sexual partners** | His wife, no other partners. |
| **Safety in relationship** | No safety concerns. The relationship is stable and healthy. |
| **Sexual orientation** | Heterosexual. |
| **Gender identity** | **Pronouns** | He/Him. |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | Cisgender male. |
| **Sex assigned at birth** | Male. |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | Masculine presentation, no unusual or distinguishing characteristics beyond typical male presentation. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · Enjoys hiking and spending time outdoors with family on weekends.  · Avid reader of science fiction and historical novels.  · Plays video games occasionally in the evenings. |
| **Recent travel** | Recently went on a family trip to a national park. No international travel in the past year. |
| **Diet** | **Typical day’s meals** | · **Breakfast:** Usually has a quick meal, such as a cup of coffee and toast or cereal.  · **Lunch:** A sandwich (often deli meat) or a salad with some protein (chicken or tuna).  · **Dinner:** Typically a home-cooked meal, including pasta, grilled chicken, or stir-fried vegetables with rice. |
| **Recent meals** | · Recently had pizza for dinner on a family movie night.  · Enjoyed grilled fish and vegetables for a healthier dinner. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | Tries to avoid fried foods, but occasionally indulges in fast food. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | No special diet, but has been trying to cut back on carbs and fried foods recently due to concerns about health (though it’s inconsistent). |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | · Walks for 30 minutes every day after work.  · Occasionally participates in weekend hiking trips with his family.  · Used to lift weights at the gym but stopped due to groin pain. |
| **Recent changes to exercise/activity (and reason for change)** | · Stopped weightlifting about a month ago because of groin pain.  · Reduced walking intensity in the past few weeks due to discomfort. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | · Regular sleep schedule; typically gets 7-8 hours of sleep per night.  · Reports good sleep quality, although the groin pain occasionally wakes him up at night.  · No recent changes to sleep patterns other than minor disturbances due to pain. |
| **Stressors** | **Work** | · High workload, with physical labor that includes lifting heavy boxes, which has recently become more difficult due to groin pain.  · Stress related to trying to keep up with the physical demands of the job and managing pain. |
| **Home** | · No significant stressors at home.  · Family life is stable and supportive. |
| **Financial** | No major financial concerns. Comfortable with his current income. |
| **Other** | Mild stress from not being able to fully participate in physical activities due to the groin pain. Concern about the potential need for surgery or ongoing pain management. |

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

|  |
| --- |
| · **Inspection:** A small, palpable lump in the right groin area, visible when the patient stands and strains.  · **Palpation:** The lump is firm and non-reducible with palpation. No signs of tenderness on the skin over the lump.  · **Cough test:** The lump increases in size when the patient coughs or bears down.  · **Auscultation:** Normal bowel sounds. No abnormal findings in the abdomen or groin. |

**Prompts and Special Instructions:**

|  |  |
| --- | --- |
| **Questions the SP MUST ask/ Statements patient must make** | · "Do you think this could be something serious?"  · "I’m concerned that I might have a hernia. What can I do about it?"  · "Is surgery necessary for something like this?"  · "Will this go away on its own, or should I be worried about complications?" |
| **Questions the SP will ask if given the opportunity** | · "What do you think could be causing this?"  · "Do you think lifting heavy boxes could have caused this?"  · "Could this turn into something more serious?" |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | · Diagnosis of inguinal hernia.  · Plan for either conservative management (if asymptomatic or reducible) or referral for surgery if necessary. |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | None provided; SP unaware of potential test results or imaging findings |