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 Lee  
**Age:** 45  
**Gender:** Female  
**Chief Complaint:** Sudden weakness on the left side of my face.

**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:** Anxious, slightly distressed, but trying to remain calm.  · **Speech:** Slow, slightly slurred at times, especially on the left side.  · **Body Language:** Left side of the face droops; visibly tries to raise eyebrows or smile but fails to do so symmetrically.  · **Non-verbal communication:** Frequent use of the right hand to touch or adjust the left side of her face, showing mild discomfort.  · **Emotional Expression:** Worries about the impact of the facial weakness, but no signs of depression or extreme anxiety. |

**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 noticed that the left side of my face feels really weak over the past couple of days. It happened all of a sudden. I can’t smile properly, and my eye won’t close fully on that side either. It’s just... kind of droopy, and I’m worried it might be something serious." |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · "I woke up two mornings ago and noticed that my left cheek felt a bit numb. The weakness seems to have gotten worse since then, and now I can’t blink with my left eye. I don’t have any pain, but it feels really strange."  · **Social History:** “I’m stressed at work lately with some deadlines and a lot of pressure. I’ve also been trying to balance home life with my family.” |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | * + "I’ve been healthy overall. No previous issues with my face, no stroke or anything like that. No major illnesses in my history either."   + **Family History:** "My mother had a stroke about five years ago, but she recovered well. No one else in my family has had anything like this."   + **Medications:** “I’m not on any regular medications. I take occasional ibuprofen for headaches, but nothing more than that.”   + **Previous Hospitalizations:** “I’ve never been hospitalized for anything major.” |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | · **Stress Factors:** "I’ve been feeling a lot of stress at work recently, but I don’t think that has anything to do with it."  · **Recent Cold or Infection:** “I had a mild cold last week, but I didn’t think much of it. Could it be related?”  · **No recent trauma or injury to the head or face.** |

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

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

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| **Quality/Character** | Weakness and drooping of the left side of the face. |
| **Onset** | Sudden onset two days ago upon waking. |
| **Duration/Frequency** | Persistent since onset. |
| **Location** | Left side of the face. |
| **Radiation** | No radiation to other areas of the face or body. |
| **Intensity (e.g. 1-10 scale for pain)** | Mild to moderate weakness (self-reported on a scale of 4/10). |
| **Treatment (what has been tried, what were the results)** | No treatments have been attempted yet. |
| **Aggravating** **Factors (what makes it worse)** | Stress at work and lack of sleep may be making it worse. |
| **Alleviating** **Factors (what makes it better)** | Rest seems to help slightly, but the weakness persists. |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | Recent cold (mild symptoms) and high-stress work environment. |
| **Associated** **Symptoms** | · Inability to close the left eye fully (difficulty blinking).  · Drooping of the left corner of the mouth, difficulty smiling symmetrically. |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | Sarah is worried that her facial appearance will be permanently affected. She is concerned about the potential impact on her career (meetings with clients, public speaking). She also fears this may be a sign of a more serious neurological problem, like a stroke. |

**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:** No fever, weight loss, or fatigue.  · **Skin:** No rashes or skin changes.  · **HEENT:** Complains of left facial drooping and difficulty closing left eye. No eye pain.  · **Endocrine:** No changes in temperature regulation, sweating, or hair changes.  · **Respiratory:** No shortness of breath, cough, or wheezing.  · **Cardiovascular:** No chest pain, palpitations, or irregular heartbeat.  · **Gastrointestinal:** No nausea, vomiting, diarrhea, or abdominal pain.  · **Urinary:** No changes in urination or discomfort.  · **Reproductive:** No concerns.  · **Musculoskeletal:** No joint pain or muscle weakness elsewhere in the body.  · **Neurologic:** Left facial weakness, no headache, no visual disturbances, no loss of consciousness.  · **Psychiatric/Behavioral:** Feeling stressed due to work pressure. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | Generally healthy, no history of neurological problems. |
| **Hospitalizations** | None. |
| **Surgical History** | None. |
| **Screening/Preventive (including vaccinations /immunizations)** | Regular physical exams. Current on all vaccinations. |
| **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** | Occasional ibuprofen for headaches. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | · **Medications:** None.  · **Environmental:** None.  · **Food:** None. |
| **Gynecologic History** | **Menstrual History:**   * + **Age at Menarche:** 13 years old.   + **Menstrual Cycle:** Regular, occurring every 28-30 days.   + **Duration of Periods:** Typically 4-5 days.   + **Flow:** Normal flow, no history of heavy or light periods.   + **Pain:** Mild cramping (dysmenorrhea) during the first day of menstruation, managed with over-the-counter ibuprofen.   + **Recent Changes:** No significant changes in menstrual cycle or flow in the past few years.   **Obstetric History:**   * + **Gravida:** 2 (two pregnancies).   + **Para:** 2 (two live births).   + **Pregnancy Details:**     - First pregnancy at age 28, vaginal delivery, no complications.     - Second pregnancy at age 32, vaginal delivery, no complications.   + **Miscarriages/Abortions:** None.   + **History of Preterm Labor:** None.   + **Contraceptive Use:** Currently using oral contraceptive pills (OCPs), taken regularly for the past 8 years.   **Gynecological Conditions:**   * + No history of polycystic ovary syndrome (PCOS), fibroids, or endometriosis.   + No history of abnormal Pap smears or cervical dysplasia.   + No history of pelvic inflammatory disease (PID).   **Sexual History:**   * + **Sexual Activity:** Sexually active with her husband (monogamous).   + **Contraceptive Method:** Oral contraceptive pills (OCPs), used consistently for many years.   + **Sexual Orientation:** Heterosexual.   + **Sexual Health Concerns:** No concerns or issues with sexual health. Reports a healthy sexual relationship with her husband.   + **STI History:** No history of sexually transmitted infections. Both partners are monogamous.   **Menopause:**   * + **Age:** Not yet menopausal.   + **Symptoms:** No significant symptoms of perimenopause, no hot flashes or night sweats.   + **Family History:** Mother had natural menopause at age 50. |

**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** | · **Mother:**   * · **Age:** 70 years old. * **Health Status:** Generally healthy, with no major ongoing health conditions. * **Notable Medical History:** Had a **stroke** at age 60, but fully recovered after rehabilitation. No lasting effects or functional impairment. * **Cause of Death:** Still living, no significant health issues currently.   · **Father:**   * · **Age:** 72 years old. * **Health Status:** Healthy, no chronic illnesses reported. * **Notable Medical History:** No significant health issues, no history of cardiovascular disease, diabetes, or cancer. * **Cause of Death:** Still living, no significant health concerns.   · **Siblings:**   * · **Brother (older):**   + **Age:** 48 years old.   + **Health Status:** Healthy, no chronic illnesses or significant health issues. * **Sister (younger):**   + **Age:** 41 years old.   + **Health Status:** Healthy, no major medical conditions.   · **Paternal Grandparents:**   * · **Paternal Grandfather:** Age at death 78, died of **heart disease**. * **Paternal Grandmother:** Age at death 82, died of **breast cancer**.   · **Maternal Grandparents:**   * · **Maternal Grandfather:** Age at death 85, died of **stroke**. * **Maternal Grandmother:** Age at death 79, died of **diabetes-related complications**. |
| **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** who are not listed above (e.g., aunts, uncles, cousins). * For family members that are not clearly listed with specific health details, the SP should state:   + "I am unsure about the health status of my paternal grandparents. My maternal side seems to have had a few health conditions like stroke and diabetes, but I don’t know all the details."   + **If asked about health conditions in extended family** (such as aunts/uncles): "I'm not sure about the health of my extended family, but everyone immediate to me has been fairly healthy." * **Reassure the learner** that the immediate family members (parents and siblings) are all alive and well, with no significant health concerns. |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Stroke (Mother's History):** The patient’s mother had a stroke at age 60, but she made a full recovery after several months of rehabilitation, including physical and speech therapy. She has not experienced any complications since.  **Breast Cancer (Paternal Grandmother's History):** The paternal grandmother had breast cancer, which led to her death at age 82. No further details on treatment are provided.  **Heart Disease (Paternal Grandfather's History):** The paternal grandfather died of heart disease at age 78. No known history of hypertension, but the family generally had an active lifestyle and balanced diet.  **Diabetes (Maternal Grandmother's History):** The maternal grandmother had diabetes-related complications, though details about her treatment regimen are unclear. The condition was managed with diet and insulin. No other family members have been diagnosed with diabetes. |

**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)** | **None** |
| **Tobacco Use** | Non-smoker |
| **Alcohol Use** | Drinks alcohol socially (1-2 glasses of wine a week). |
| **Home Environment** | **Home type** | Sarah lives in a **single-family house** with a small yard in a suburban area. The house is two stories with 3 bedrooms, 2 bathrooms, a kitchen, and a living room. It’s well-kept and comfortable. |
| **Home Location** | **Suburban neighborhood**, quiet and family-friendly. The house is located near parks and local shops. It is about a 15-minute drive from the nearest medical facility. |
| **Co-habitants** | · **Husband (John Lee), age 42**: Works as an IT consultant. He is Sarah’s primary source of emotional and physical support.  · **Children:**   * **Daughter (Emily), age 8**: Healthy, attends school locally. * **Son (Oliver), age 5**: Healthy, attends daycare.   · No other family members or roommates live in the house. |
| **Home Healthcare devices (for virtual simulations)** | · **Blood pressure monitor:** Used occasionally when Sarah feels stressed or concerned about her health.  · **Pulse oximeter:** Occasionally used for general wellness checks, especially since her mother had a stroke.  · **No other specialized healthcare devices**. | |
| **Social Supports** | **Family & Friends** | · **Family Support:** Sarah's immediate family (husband, children, and parents) provide significant emotional support. She regularly communicates with her parents by phone and visits them every few weeks.  · **Friends:** A close-knit group of three friends. They occasionally meet for coffee and social gatherings. She values this social support and sees friends at least once or twice a month.  · **Social Network:** Sarah is part of a neighborhood mothers' group where they meet for playdates, school events, and casual social activities. |
| **Financial** | · **Financial Stability:** Sarah and her husband are both employed, and they live comfortably. They don’t have significant financial stress, though Sarah occasionally worries about saving for the children’s future education costs.  · **Income:** The family is middle-class, with a dual-income household. John has a stable job, and Sarah works part-time as an administrative assistant. |
| **Health care access and insurance** | · **Health Insurance:** Sarah has health insurance through her husband’s employer. The plan covers medical, dental, and vision care for the whole family, with a reasonable deductible and co-pays.  · **Healthcare Access:** Sarah has a regular primary care provider and takes the children to well-child visits annually. She has quick access to healthcare facilities, given the proximity of her home to medical centers. |
| **Religious or Community Groups** | · **Community Involvement:** Sarah attends a local church, though she is not highly involved in activities. She does participate in occasional community events like charity fundraisers and volunteer opportunities.  · **Religious Beliefs:** Sarah identifies as **Christian** but does not attend services weekly. She considers herself spiritually active and finds peace in personal reflection and prayer. |
| **Education and Occupation** | **Level of Education** | Sarah completed her **Bachelor’s degree in English Literature** at a state university. She graduated in 2002. |
| **Occupation** | Sarah works part-time as an **administrative assistant** in a local law firm. She enjoys her work and finds it fulfilling, though she occasionally feels stretched by balancing work and family responsibilities. |
| **Health Literacy** | Sarah is considered to have **high health literacy**, as she is proactive about managing her family’s health and reads up on medical conditions when necessary. She’s familiar with the basic functions of healthcare and how to access care, but she prefers explanations in layman’s terms for complex medical topics. |
| **Sexual History:** | **Relationship Status** | * · **Married** to John Lee, whom she has been with for 10 years. They have a stable and loving relationship. |
| **Current sexual partners** | * · **Husband (John Lee)**, sexually active, monogamous relationship. |
| **Lifetime sexual partners** | · **3 lifetime sexual partners** (including her husband).  · Sarah has been with her husband since they met in college, and she has had no other sexual partners since then. |
| **Safety in relationship** | Sarah feels **safe and supported** in her relationship. There are no concerns about abuse or unhealthy dynamics. |
| **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)** | Sarah presents as **cisgender female** with **feminine style** in terms of dress, hair, and grooming. She is in her late 30s and has an approachable, well-groomed look. She does not exhibit any androgynous traits. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · Sarah enjoys reading, particularly historical fiction and contemporary novels.  · She likes gardening and spends time outdoors in her garden, especially during the spring and summer.  · Sarah enjoys baking and often tries new recipes on weekends.  · She is also an avid **movie-goer** and likes to watch films with her husband, especially on Friday nights. |
| **Recent travel** | * + Sarah and her family took a **week-long vacation to the beach** last summer. They are planning a **trip to visit her in-laws** in the mountains next holiday season. |
| **Diet** | **Typical day’s meals** | · **Breakfast:** Oatmeal with fresh fruit or a smoothie with spinach, berries, and protein powder.  · **Lunch:** A salad with chicken, avocado, and a variety of vegetables, or leftovers from dinner.  · **Dinner:** A balanced meal such as grilled chicken, quinoa, and roasted vegetables. Sometimes a pasta dish.  · **Snacks:** Fresh fruits, nuts, and occasionally, granola bars. |
| **Recent meals** | Last night's dinner was **grilled salmon**, rice, and sautéed spinach. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | Sarah tries to avoid **fried foods** and **processed snacks**. She is cautious about sugar intake but does enjoy sweets occasionally. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | No specific dietary restrictions or allergies, but Sarah tries to maintain a **balanced diet** for herself and her family. |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | Sarah **exercises 3 times a week**:   * **Monday:** 30-minute walk around the neighborhood with her children. * **Wednesday:** Yoga class. * **Friday:** 45-minute home workout session (combination of strength training and cardio). |
| **Recent changes to exercise/activity (and reason for change)** | * + Sarah **recently increased** her workout frequency due to feeling like she needed to get in better shape after a busy few months of family and work commitments. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern:**   * + Sarah usually goes to bed around **11 PM** and wakes up at **7 AM**. She follows a consistent sleep schedule.   **Length:**   * + Typically sleeps **7-8 hours** a night.   **Quality:**   * + Generally, Sarah has **good-quality sleep**, though she occasionally has difficulty falling asleep after stressful days.   **Recent Changes:**   * + Recently, Sarah has noticed **occasional insomnia** due to increased work stress. She finds it difficult to "shut her mind off" at night. |
| **Stressors** | **Work** | * · **Balancing work and family life** has been a source of stress. Sarah feels overwhelmed at times by her dual responsibilities. |
| **Home** | Occasionally stressed about household chores and managing the children’s schedules, particularly when her husband is traveling for work. |
| **Financial** | **Saving for children's education** has been a recent stressor. Sarah feels the need to save more aggressively but also wants to balance it with enjoying life now. |
| **Other** | No major additional stressors. She is generally well-supported by her family and friends. |

**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:** Appears anxious but otherwise well-nourished and healthy. * **Vital Signs:** Blood pressure 120/78, heart rate 78, respiratory rate 16, temperature 98.6°F. * **Neurologic Exam:**   + Left side of face shows mild to moderate weakness (unable to smile symmetrically, unable to close left eye fully, left eyebrow is unable to raise).   + No other motor deficits, no sensory loss on face.   + Cranial nerve exam reveals weakness in facial nerve on the left (Bell’s palsy pattern).   + Reflexes are normal. * **Cranial Nerve Exam:**   + Facial Nerve (VII): Asymmetric facial movements, left side facial drooping, inability to close left eye or raise left eyebrow.   + All other cranial nerves intact (no abnormal findings on other cranial nerve exams). |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | · **Question:** "Could this be something serious like a stroke?"  · **Question:** "Is there anything I can do to speed up recovery?"  · **Statement:** "I’m worried that my face will be permanently affected." |
| **Questions the SP will ask if given the opportunity** | * **"What do you think might be causing this weakness in my face?"**   + This question might come up after Sarah describes the sudden onset of facial drooping or weakness. It allows the learner to discuss potential causes and begin evaluating the situation.  **2. Question about Treatment Options:**  * **"Is there any treatment for this kind of problem? Will I get better?"**   + Sarah is likely to be concerned about the prognosis and effectiveness of treatment options. This question helps assess whether the learner can explain the treatment plan and the expected course of the condition.  **3. Question about Impact on Daily Life:**  * **"Do you think this will affect my ability to take care of my family or go back to work?"**   + This question reflects Sarah's concerns about the functional impact of her symptoms, especially on her responsibilities at home and work. It also allows the learner to discuss the functional limitations that may arise from facial nerve palsy.  **4. Question about Diagnosis Clarification:**  * **"Could this be something serious, like a stroke or something worse?"**   + After discussing her symptoms, Sarah might worry that something more serious is at play. This question allows the learner to differentiate between possible diagnoses and explain the signs of a stroke versus facial nerve paralysis.  **5. Question about Emotional Support:**  * **"Will I need any special support while I recover from this? Should I talk to someone about how I’m feeling?"**   + This question indicates Sarah’s awareness of the emotional toll her condition might have on her, prompting the learner to consider psychological support or counseling.  **6. Question about Follow-up:**  * **"How long should I expect to be dealing with this? When should I come back for a follow-up appointment?"**   + Sarah may be curious about the timeline for recovery, especially regarding the potential length of facial nerve palsy. This question helps the learner address follow-up care and timeline expectations.  **7. Question about Risk Factors:**  * **"Is there anything I should avoid that could make my condition worse?"**   + Sarah may be concerned about whether certain activities (e.g., stress, physical exertion, or environmental factors) could worsen her condition. This question allows the learner to provide guidance on lifestyle changes, caution, and preventive measures.  **8. Question about Medication:**  * **"Do I need any medications, or is there something I should take to help with this?"**   + This question indicates Sarah’s interest in potential pharmaceutical treatments for her condition, allowing the learner to discuss options like corticosteroids or antiviral medication (if applicable) for conditions like Bell's palsy.  **9. Question about the Cause of Her Condition:**  * **"Can you explain why this happened to me? I’ve never had anything like this before."**   + This question can help the learner explore potential underlying causes of facial nerve paralysis, such as viral infections, trauma, or idiopathic factors, and provide Sarah with an explanation she can understand.  **10. Question about Long-Term Effects:**  * **"Will this leave permanent damage to my face?"**   + As someone who may be concerned about aesthetics and self-image, Sarah might ask this question to understand if there will be any lasting consequences to her facial appearance or functionality. |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | Diagnosis of Bell's Palsy (facial nerve palsy), possible treatment options (e.g., corticosteroids, physical therapy), and reassurance regarding prognosis. |
| **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 know Sarah has a history of mild stress, but this may not be immediately relevant to the condition being presented. |