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:** Emma Harris

**Age:** 45

**Gender:** Female

**Chief Complaint:** "I’ve had the worst headache of my life, and I’ve been feeling nauseous."

**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, slightly tearful, but cooperative.  · **Speech:** Short responses, but clear and understandable. Sometimes pauses as if trying to focus.  · **Body Language:** Holding her head with both hands, tense posture. Appears uncomfortable and in mild distress.  · **Non-Verbal Cues:** Keeps rubbing her forehead and seems light-sensitive when exposed to light.  · **Tone:** Tense, occasionally shaky. Can become increasingly emotional when describing the pain and 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)** | **Opening Statement:** "I'm feeling terrible today. I woke up with this sudden, severe headache, and it just keeps getting worse. It’s like nothing I’ve ever felt before."  **Response to "What brings you in today?"** “I’ve had this unbearable headache, and it’s been making me feel sick to my stomach. I’m also getting dizzy and lightheaded." |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · **Nausea and Vomiting:** "I’ve been nauseous all morning, and I’ve thrown up a couple of times. The headache just won’t go away."  · **Light Sensitivity:** "I can’t stand bright lights. They make the headache worse."  · **Neck Stiffness:** "My neck feels stiff too, which is odd."  · **Previous History of Similar Headaches:** "I’ve had migraines before, but this feels completely different." |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · **Recent Physical Exertion:** "I did a bit of heavy lifting yesterday. I’m not sure if that triggered this, but I don’t normally have headaches like this after working out."  · **Family History:** "My mother had a stroke in her late 50s, but I don’t know much about her medical history beyond that."  · **Hypertension:** "I was told I have borderline high blood pressure, but I haven’t been on any medication for it." |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | · **Recent Stress or Anxiety:** "I’ve been under a lot of stress at work, but I don’t think that’s relevant to why I’m feeling like this."  · **Not Mentioning Sudden Onset:** "I didn’t experience any trauma or injury. This just came on out of nowhere." |

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

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

|  |  |
| --- | --- |
| **Quality/Character** | "The pain is sharp, stabbing, and intense. It feels like someone is squeezing my head." |
| **Onset** | "It started suddenly this morning, about two hours ago." |
| **Duration/Frequency** | "It’s been constant, and it hasn’t improved at all." |
| **Location** | "It’s mostly around my forehead and the back of my head." |
| **Radiation** | "I don’t feel the pain going anywhere else." |
| **Intensity (e.g. 1-10 scale for pain)** | "On a scale of 1 to 10, it’s a 9." |
| **Treatment (what has been tried, what were the results)** | "I’ve taken some over-the-counter painkillers, but they haven’t helped." |
| **Aggravating** **Factors (what makes it worse)** | "Anything, like movement or light, makes it worse." |
| **Alleviating** **Factors (what makes it better)** | "Nothing seems to help right now." |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | "I didn’t do anything different today. It just came on suddenly." |
| **Associated** **Symptoms** | "I’ve been feeling lightheaded, and I feel nauseous all the time." |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | "I’m really scared. I’ve never had anything like this before, and it’s not going away." |

**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:** Denies fever or chills.  · **Skin:** No rashes, itching, or changes to skin appearance.  · **HEENT:** Severe headache as described; photophobia; no significant vision changes or ear problems.  · **Endocrine:** No known thyroid issues.  · **Respiratory:** Denies shortness of breath, coughing, or wheezing.  · **Cardiovascular:** Denies chest pain or palpitations.  · **Gastrointestinal:** Nausea, vomiting, no changes in bowel habits.  · **Urinary:** Normal urine output, no dysuria.  · **Reproductive:** Menstruating regularly, no complaints.  · **Musculoskeletal:** No joint or muscle pain, but stiff neck.  · **Neurologic:** No previous neurological problems, some dizziness and lightheadedness today.  · **Psychiatric/Behavioral:** Some anxiety due to severity of headache, but no history of depression or psychiatric disorders. |

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

|  |  |
| --- | --- |
| **Illnesses/Injuries (chronic or otherwise relevant)** | Hypertension (diagnosed a few years ago, untreated). |
| **Hospitalizations** | None. |
| **Surgical History** | None. |
| **Screening/Preventive (including vaccinations /immunizations)** | Normal Pap smear last year, annual blood pressure checks. |
| **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 regular medications. Occasionally takes ibuprofen for minor headaches. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | · No known drug allergies.  · Mild seasonal allergies (allergic rhinitis). |
| **Gynecologic History** | Regular menstrual cycles, no known 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** | · **Mother**:   * · **Age**: 70 (alive) * **Health Status**: Hypertension (managed with medication), history of stroke at age 58. Currently lives independently but requires assistance with mobility after stroke.   · **Father**:   * · **Age**: 72 (alive) * **Health Status**: No chronic illnesses reported, currently healthy.   · **Sibling (Older Brother)**:   * · **Age**: 48 (alive) * **Health Status**: Healthy, no known chronic diseases.   · **Maternal Grandfather**:   * · **Age at Death**: 79 * **Cause of Death**: Heart attack, history of cardiovascular disease.   · **Paternal Grandfather**:   * · **Age at Death**: 80 * **Cause of Death**: Cancer (unspecified).   · **Paternal Grandmother**:   * · **Age at Death**: 85 * **Cause of Death**: Natural causes. |
| **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:** "I'm not entirely sure about my paternal grandparents' health conditions. My father was not very open about their health histories."  · · **Additional Family Members:** "I don't have any other family members that are relevant to mention at this point." |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Mother's Hypertension:**   * + Managed with medication (unspecified).   + Has had regular follow-ups with her primary care provider.   + Slightly higher risk for stroke, as noted by the physician.   **Mother’s Stroke (age 58):**   * + After suffering a stroke, she had some physical rehabilitation but still experiences some weakness on her left side. She now lives independently, though requires help with daily activities such as shopping and heavy chores.   **Father’s Health:**   * + No chronic conditions or medications. Regular check-ups with no major health concerns. |

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

|  |  |  |
| --- | --- | --- |
| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | Denies use. |
| **Tobacco Use** | Denies use. |
| **Alcohol Use** | Occasionally drinks wine, 1-2 times per week. |
| **Home Environment** | **Home type** | * Lives in a two-bedroom apartment on the second floor of a building in an urban area. * The building does not have an elevator, so there are stairs. |
| **Home Location** | · The apartment is in a suburban neighborhood with moderate foot traffic.  · It is about a 20-minute drive from the hospital and 10 minutes from the nearest clinic. |
| **Co-habitants** | Lives alone, no roommates or immediate family members residing with her. |
| **Home Healthcare devices (for virtual simulations)** | · Blood pressure cuff (measures at home irregularly).  · No other healthcare devices (e.g., pulse oximeter, glucometer) in use at home. | |
| **Social Supports** | **Family & Friends** | · Limited family support nearby, as most relatives live in another state.  · Occasionally visits her mother for assistance with grocery shopping.  · Has a small circle of close friends who offer emotional support. |
| **Financial** | · Works part-time as a receptionist at a local office.  · Financial situation is relatively stable but tight; lives paycheck to paycheck. |
| **Health care access and insurance** | · Has health insurance through her employer, which covers doctor visits and prescription medications.  · Occasionally struggles to afford copays for certain specialist consultations, especially after a hospital visit. |
| **Religious or Community Groups** | · Attends church on weekends, though not very involved in any specific community groups.  · Engages in social gatherings with friends occasionally, but more so for emotional support than spiritual guidance. |
| **Education and Occupation** | **Level of Education** | · High school graduate, completed some community college coursework but never obtained a degree.  · Has basic computer literacy and performs clerical tasks at her job. |
| **Occupation** | · Works as a receptionist at a small medical office, which involves answering calls, scheduling appointments, and basic office tasks.  · Has been working part-time in this role for the past 3 years. |
| **Health Literacy** | · Good basic health literacy, able to understand medical instructions and terms with some assistance.  · Can understand most common medical conditions and medications but may have difficulty grasping complex medical jargon without clarification. |
| **Sexual History:** | **Relationship Status** | Single, not currently in a relationship. |
| **Current sexual partners** | None. |
| **Lifetime sexual partners** | Has had two lifetime sexual partners. |
| **Safety in relationship** | No history of abusive relationships. |
| **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)** | Dresses in a casual, modest style; generally prefers comfortable clothing like jeans and t-shirts. Hair is kept shoulder-length and often tied back in a ponytail. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · Enjoys reading mystery novels and watching true crime documentaries.  · Likes gardening in her apartment balcony and going for walks in the nearby park when the weather is nice. |
| **Recent travel** | · Took a short weekend trip to visit family a few months ago.  · No recent international or long-distance travel. |
| **Diet** | **Typical day’s meals** | · Breakfast: Cereal with milk or toast with peanut butter.  · Lunch: Sandwich (turkey, lettuce, and tomato) with chips and water.  · Dinner: Rotating meals (pasta, grilled chicken, or vegetable stir-fry). |
| **Recent meals** | · Last night had pasta with marinara sauce and a side salad.  · The day before, had a quick meal of frozen pizza. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | · Does not typically eat fried foods, due to a mild preference for healthier options. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | Follows a balanced diet but doesn't strictly adhere to any specific plan (e.g., no formal vegetarian or keto diet). |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | · Walks 30 minutes every day around the neighborhood or at the local park.  · Occasionally participates in low-impact home workout routines, like yoga or stretching. |
| **Recent changes to exercise/activity (and reason for change)** | · Recently reduced walking frequency due to mild knee pain.  · No major reason for the change other than feeling occasional discomfort. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | · Typically sleeps 7-8 hours a night.  · Has had some trouble falling asleep recently due to stress and worrying about health.  · Usually falls asleep by 11 PM and wakes up around 7 AM. |
| **Stressors** | **Work** | · Feels occasional stress at work due to high call volumes and administrative tasks.  · Recently overwhelmed by feeling like she's not advancing in her career. |
| **Home** | Minor stress from living alone, though she enjoys her privacy. |
| **Financial** | Occasional worry about making ends meet, especially when unexpected medical expenses arise. |
| **Other** | · Health-related stress from her ongoing headache and potential underlying condition.  · Occasionally feels overwhelmed by the pressure of managing her health alone. |

**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:** Alert but distressed, holding head. * **Vital Signs:**   + BP: 145/92 mmHg (elevated, consistent with known hypertension)   + HR: 98 bpm (tachycardia)   + RR: 18 breaths/min   + Temperature: 98.7°F * **HEENT:**   + Head: Tenderness to palpation over the scalp, no external injuries.   + Eyes: Pupils equal and reactive, mild photophobia.   + Neck: Stiffness on palpation, no palpable masses. * **Cardiovascular:** Regular rhythm, no murmurs or gallops. * **Respiratory:** Clear breath sounds bilaterally. * **Neurologic:**   + Cranial nerves II-XII intact.   + Mild lightheadedness, no focal deficits.   + Negative Romberg test. * **Musculoskeletal:** No muscle tenderness or swelling. |

**Prompts and Special Instructions:**

|  |  |
| --- | --- |
| **Questions the SP MUST ask/ Statements patient must make** | · **“Can you help me? I don’t know what’s going on. This pain is unbearable.”**  · **“I’m scared this might be something serious, like a stroke.”**  · **“Is there anything you can do to stop the pain? It’s all I can think about right now.”** |
| **Questions the SP will ask if given the opportunity** | · **Do you think this headache could be related to my blood pressure? I’ve had borderline high blood pressure before."** (The SP is concerned that her previous history of hypertension may be contributing to her current symptoms.)  · · **"What kind of tests or scans will I need? Will I need an MRI or CT scan?"** (The SP is worried about the possibility of something serious, like a stroke or aneurysm, and wants to know if any imaging tests will be necessary.)  · · **"Can this type of headache be treated with painkillers, or should I avoid medication right now?"** (The SP is seeking guidance on whether taking over-the-counter pain relief, like ibuprofen or aspirin, could be harmful or helpful.)  · · **"How serious is this? Could it be a stroke? Should I be worried?"** (The SP is anxious and seeks reassurance, wondering whether her symptoms indicate a stroke or other serious condition.)  · · **"Should I continue to monitor my blood pressure at home? How often should I be checking it?"** (The SP wants to know if she should continue monitoring her blood pressure given her past history of hypertension and her current symptoms.)  · · **"What can I do to ease the pain in the meantime? Will this get better on its own?"** (The SP is looking for suggestions on how to manage the pain while awaiting a diagnosis.)  · · **"Could this be something else, like a migraine or tension headache? I’ve had migraines before, but this one feels different."** (The SP is considering alternative causes for the headache and wondering if it might be something she has experienced in the past.)  · · **"Are there any warning signs that I should look out for in the next few hours or days?"** (The SP wants to understand if there are any symptoms or changes that could suggest the condition is worsening and require immediate attention.)  · · **"Is it safe for me to go home today? Do I need to be admitted to the hospital?"** (The SP is anxious about whether the headache indicates a serious issue and whether she needs to be hospitalized.)  · · **"Could stress be making this worse? I’ve been under a lot of pressure lately."** (The SP may be wondering if her stress or lifestyle could be a contributing factor to the severity of the symptoms.) |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | The learner should recognize the possible diagnosis of Subarachnoid Hemorrhage (SAH) and take immediate action to refer for diagnostic tests, such as a CT scan or lumbar puncture, and manage the patient’s pain and anxiety. Ideally, they would provide reassurance while escalating care as needed. |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | Yes. The learner may know that a subarachnoid hemorrhage is highly likely, especially given the sudden onset of severe headache, nausea, vomiting, photophobia, and neck stiffness, which are key clinical signs. |