

NURS 612 Shadow Health All Modules Cases Instructor Keys

written by

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ADVANCED HEALTH ASSESSMENT

Health History - TINA JONES™

“ I got this scrape on my foot a while ago, and I thought it would heal up on its own, but now it's looking pretty nasty. And the pain is killing me!

Module 1 - Health History

Ms. Jones is a pleasant, 28-year-old obese African American single woman who presents to establish care and with a recent right foot injury. She is the primary source of the history. Ms. Jones offers information freely and without contradiction. Speech is clear and coherent. She maintains eye contact throughout the interview.

Timeframe: 1 week after fall (Age: 28)

Reason for visit: Patient presents for an initial primary care visit today complaining of an infected foot wound.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Information Processing Activity
- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

High Priority

- Acute pain of the foot
- Local infection of skin and subcutaneous tissue of the foot
- Uncontrolled type 2 diabetes mellitus

Low Priority:

- Acanthosis nigricans
- Asthma
- Dysmenorrhea
- Hirsutism
- Hypertension

- Menorrhagia
- Obesity
- Oligomenorrhea
- Polycystic ovarian syndrome



ADVANCED HEALTH ASSESSMENT

Health History - TINA JONES™

History of Present Illness

One week after sustaining the cut, Tina Jones develops an infection in the cut on the bottom of her foot; she seeks treatment when the infection starts to swell and produce pus.

Day 1 (Onset): Tina was at home, going down the back steps, and she tripped. She turned her ankle and scraped the bottom of her foot. The wound bled, but she stopped the bleeding quickly and cleaned the wound. She worried that she had sprained her ankle, and her mom drove her to the ER. ("a week ago")

The ER did an xray (no broken bones), gave her a prescription for Tramadol, and sent her home. In the following days, her ankle seemed fine not as serious as she thought.

Day 2 - 4: She cleaned the wound dutifully, twice a day, with soap and water or hydrogen peroxide, let it dry, put Neosporin on it, and bandaged it. The wound wasn't getting worse, but it wasn't healing, either. She expresses that she "took really good care of it." Tina was able to go to work and attend school.

Day 4: Tina went to her cousin's house, where she encountered cats and experienced wheezing. She tried two puffs on her albuterol inhaler, and she had to do a third puff. ("three days ago")

Day 5 - 6: Tina noticed pus in the wound, and swelling, redness and a warm feeling in her foot. Her pain increased to the point she was unable to walk. She began to take the Tramadol to try to manage the pain, but it didn't resolve the pain completely. She missed class and work. ("two days ago")

On the night of Day 6: Tina started to run a fever. They took her temperature at home, and it was 102. ("last night")

Morning of Day 7: Tina finally recognizes that her foot infection is not going to get better, and her mom takes her to the nurse practitioner to get the foot looked at.

Subjective and Objective Model Documentation

Printable "Answer Key" available within the Shadow Health DCE.

Chief Complaint

- Symptoms - Foot pain and discharge
- Diagnosis - Infected foot wound

Vitals

- | | |
|------------------------------|--------------------------------|
| • Weight (kg) - 88 | • Pulse Oximetry - 99% |
| • BMI - 30.5 | • Blood Pressure (BP) - 139/87 |
| • Heart Rate (HR) - 82 | • Blood Glucose - 117 |
| • Respiratory Rate (RR) - 16 | • Temperature (F) - 98.9 |

Medications

- | | |
|---|--|
| 1. Acetaminophen 500-1000 mg PO prn (headaches) | 4. Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (last use: "a few months ago") |
| 2. Ibuprofen 600 mg PO TID prn (menstrual cramps) | |
| 3. Tramadol 50 mg PO BID prn (foot pain) | |

Allergies

- Penicillin: rash
- Denies food and latex allergies
- Allergic to cats and dust. When she is exposed to allergens she states that she has runny nose, itchy and swollen eyes, and increased asthma symptoms.

ADVANCED HEALTH ASSESSMENT

Health History - TINA JONES™

Abnormal Findings

Reported during Chief Complaint interview

- Reports open foot wound and throbbing pain
- Rates present pain at a 7 out of 10
- Discharge, redness, swelling, and warmth around foot wound
- Reports a fever last night and presents with a fever of 101.1 F
- Pain affects ability to walk, job performance, and class attendance

Reported during Past Medical History interview

- Diagnosed with asthma in childhood and uses an inhaler 2 to 3 times per week
- Allergic to penicillin, dust and cats, which cause wheezing
- Diagnosed with Type 2 diabetes
- Does not currently take medication for diabetes and does not monitor blood glucose
- Heavy menstrual flow, heavy cramping, and irregular periods
- Occasional headaches and eye strain
- Increased thirst and more frequent urination
- Recent 10lb unintentional weight loss
- Habitual diet soda drinking

Assessment

Right foot wound with evidence of infection

Plan

1. Clean wound with normal saline and redress with clean gauze.
2. Educate patient on when to seek emergent care, signs and symptoms of infection, and daily wound care.
3. Return to clinic one week to re-evaluate wound and assess need for antibiotics.

ADVANCED HEALTH ASSESSMENT

HEENT - TINA JONES™

“My throat has been sore and itchy for a week now, and my nose won't stop running. It's not getting worse, but it's not going away either.



Module 2 - HEENT

For the last week, Tina has experienced sore, itchy throat, itchy eyes, and runny nose. She states that these symptoms started spontaneously and have been constant in nature. She has treated her throat pain with occasional throat lozenges which has “helped a little”. She states that her nose “runs all day” and has clear discharge. She denies cough and recent illness. She denies fevers, chills, and night sweats.

Timeframe: 1 month after establishing primary care (Age: 28)

Reason for visit: Patient presents complaining of nose and throat symptoms.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

J30.1, Allergic rhinitis due to pollen



ADVANCED HEALTH ASSESSMENT

HEENT - TINA JONES™

History of Present Illness

Ms. Jones is a pleasant 28-year-old African American woman who presented to the clinic with complaints of sore, itchy throat, itchy eyes, and runny nose for the last week. She states that these symptoms started spontaneously and have been constant in nature. She does not note any specific aggravating symptoms, but states that her throat pain seems to be worse in the morning. She rates her throat pain as 4/10. She has treated her throat pain with occasional throat lozenges which has "helped a little". She states that she has some soreness when swallowing, but otherwise no other associated symptoms. She states that her nose "runs all day" and is clear discharge. She has not attempted any treatment for her nasal symptoms. She states that her eyes are constantly itchy and she has not attempted any eye specific treatment. She denies cough and recent illness. She has had no exposures to sick individuals. She denies changes in her hearing, vision, and taste. She denies fevers, chills, and night sweats. She has never been diagnosed with seasonal allergies, but does note that her sister has "hay fever".

Subjective and Objective Model Documentation

Printable "Answer Key" available within the Shadow Health DCE.

Vitals

- | | |
|------------------------------|--------------------------------|
| • Weight (kg) - 89 | • Pulse Oximetry - 99% |
| • BMI - 30.8 | • Blood Pressure (BP) - 141/82 |
| • Heart Rate (HR) - 80 | • Blood Glucose - 199 |
| • Respiratory Rate (RR) - 16 | • Temperature (F) - 99.1 |

Medications

- | | |
|--|---|
| 1. Albuterol 90 mcg/spray MDI 2 puffs Q4H prn
(Wheezing: "when around cats," last use in the past week) | 2. Acetaminophen 500/1000 mg PO prn (headaches) |
| | 3. Ibuprofen 600 mg PO TID prn (cramps) |

Review of Systems

- **General:** Denies changes in weight, fatigue, weakness, fever, chills, and night sweats.
- **Head:** Denies history of trauma. Denies current headache.
- **Eyes:** She does not wear corrective lenses, but notes that her vision has been worsening over the past few years. She complains of blurry vision after reading for extended periods. Denies increased tearing or itching prior to this past week.
- **Ears:** Denies hearing loss, tinnitus, vertigo, discharge, or earache.
- **Nose/Sinuses:** Denies rhinorrhea prior to this episode. Denies stuffiness, sneezing, itching, previous allergy, epistaxis, or sinus pressure.
- **Mouth/Throat:** Denies bleeding gums, hoarseness, swollen lymph nodes, or wounds in mouth. No sore throat prior to this episode.
- **Respiratory:** She denies shortness of breath, wheezing, cough, sputum, hemoptysis, pneumonia, bronchitis, emphysema, tuberculosis. She has a history of asthma, last hospitalization was age 16 for asthma, last chest XR was age 16. Her current inhaler use has been her baseline of 2-3 times per week.

Chief Complaint

- **Symptoms** - Sore and itchy throat, runny nose, itchy eyes
- **Diagnosis** - Allergic rhinitis

ADVANCED HEALTH ASSESSMENT

HEENT - TINA JONES™

Abnormal Findings

Subjective (Reported by Tina)

- Reports sore and itchy throat for the past week
- Associated symptoms are red, itchy eyes and runny nose
- Reports unrelated occasional headaches and eye strain

Objective (Found by the student performing physical exam)

- Oropharynx slightly erythematous with mild cobblestoning
- Injection visible on conjunctiva
- Nasal mucosa pale and boggy
- Observable intermittent cough
- Left fundus with sharp disc margins, no hemorrhages; right fundus with mild retinopathic changes
- Visual acuity: 20/40 right eye, 20/20 left eye
- Acanthosis nigricans noted on neck

Assessment

Allergic Rhinitis

Plan

1. Encourage Ms. Jones to continue to monitor symptoms and log her episodes of allergic symptoms with associated factors and bring log to next visit.
2. Initiate trial of loratadine (Claritin) 10 mg by mouth daily.
3. Encourage to increase intake of water and other fluids and educate on frequent handwashing.
4. Educate on avoidance of triggers and known allergens
5. Educate Ms. Jones on when to seek care including episodes of uncontrollable epistaxis, worsening headache, or fever.
6. Revisit clinic in 2-4 weeks for follow up and evaluation.

ADVANCED HEALTH ASSESSMENT

Respiratory - TINA JONES™

“Two days ago, I had a kind of asthma attack. Since then, I've been using my inhaler a lot, and it's not helping like it usually does. I want to get my asthma back under control.”

Module 3 - Respiratory

Tina had an asthma episode 2 days ago. At that time she used her albuterol inhaler and her symptoms decreased although they did not completely resolve. Since that incident she notes that she has had 10 episodes of wheezing and has shortness of breath approximately every four hours. Tina presents with continued shortness of breath and wheezing.

Timeframe: 3 months after establishing primary care (Age: 28)

Reason for visit: Patient presents complaining of a recent asthma episode that is not fully resolved.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- **Student Performance Index** - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

J45.901, Asthma J45.901, Asthma with acute exacerbation with acute exacerbation



ADVANCED HEALTH ASSESSMENT

Respiratory - TINA JONES™

History of Present Illness

Ms. Jones is a pleasant 28-year-old African American woman who presented to the clinic with complaints of shortness of breath and wheezing following a near asthma attack that she had two days ago. She reports that she was at her cousin's house and was exposed to cats which triggered her asthma symptoms. At the time of the incident she notes that her wheezes were a 6/10 severity and her shortness of breath was a 7-8/10 severity and lasted five minutes. She did not experience any chest pain or allergic symptoms. At that time she used her albuterol inhaler and her symptoms decreased although they did not completely resolve. Since that incident she notes that she has had 10 episodes of wheezing, and has a nonproductive cough and episodes of shortness of breath approximately every four hours. Her last episode of shortness of breath was this morning before coming to clinic. She notes that her current symptoms seem to be worsened by lying flat, activity, and are accompanied by a non-productive cough. She awakens with night-time shortness of breath twice per night. She complains that her current symptoms are beginning to interfere with her daily activities and she is concerned that her albuterol inhaler seems to be less effective than previous. Currently she states that her breathing is normal. Diagnosed with asthma at age 2.5 years. She has no recent use of spirometry, does not use a peak flow, does not record attacks, and does not have a home nebulizer or vaporizer. She has been hospitalized five times for asthma, last at age 16. She has never been intubated for her asthma. She does not have a current pulmonologist or allergist.

Subjective and Objective Model Documentation

Printable "Answer Key" available within the Shadow Health DCE.

Vitals

- Weight (kg) - 89
- BMI - 30.8
- Heart Rate (HR) - 89
- Respiratory Rate (RR) - 20
- Pulse Oximetry - 97%
- Blood Pressure (BP) - 140/81
- Blood Glucose - 224
- Temperature (F) - 98.5

Medications

1. Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (Wheezing: "when around cats," last use this morning). She does admit to needed an occasional third puff for symptom relief. She reports that the inhaler does not seem to be as effective in treating her symptoms recently.
2. Acetaminophen 500-1000 mg PO prn (headaches)
3. Ibuprofen 600 mg PO TID prn (cramps)

Review of Systems

- **General:** Denies changes in weight, fatigue, weakness, fever, chills, and night sweats.
- **Nose/Sinuses:** Denies rhinorrhea with this episode. Denies stuffiness, sneezing, itching, previous allergy, epistaxis, or sinus pressure.
- **Gastrointestinal:** No changes in appetite, no nausea, no vomiting, no symptoms of GERD or abdominal pain
- **Respiratory:** Complains of shortness of breath and cough as above. Denies sputum, hemoptysis, pneumonia, bronchitis, emphysema, tuberculosis. She has a history of asthma, last hospitalization was age 16, last chest XR was age 16.

Chief Complaint

- **Symptoms** - Shortness of breath, decreased inhaler effectiveness
- **Diagnosis** - Asthma exacerbation

ADVANCED HEALTH ASSESSMENT

Respiratory - TINA JONES™

Abnormal Findings

Subjective (Reported by Tina)

- Reports recent asthma exacerbation with wheezing and shortness of breath
- Uses rescue inhaler more than prescribed and notices decreased inhaler effectiveness
- Cats, dust, and some activity are asthma triggers

Objective (Found by the student performing physical exam)

- Oxygen saturation 97%
- FVC is 3.91 L and FEV1/FVC ratio is 80.56%
- Wheeze and slight prolonged expiration upon auscultating lower posterior lungs

Assessment

Asthma exacerbation

Plan

1. Ms. Jones was encouraged to continue to monitor symptoms and log her episodes of asthma symptoms and wheezing with associated factors and bring log to next visit.
2. Obtain office oxygen saturation.
3. Order PFTs to be completed after exacerbation to have baseline available for future comparison.
4. Encouraged to wash bedding and consider dust mite covers to decrease allergic nighttime symptoms.
5. NMT in office x 1.
6. Educated to increase intake of water and other fluids.
7. Educated Ms. Jones on when to seek emergent care including episodes of chest pain or shortness of breath unrelieved by rest, worsening asthma symptoms or wheezing, or the sense that rescue inhaler is not helping.
8. Revisit clinic in 24 weeks for follow up and evaluation.




FOCUSED EXAM CASE

GRADUATE - COUGH (DANIEL "DANNY" RIVERA™)

Introduction

Daniel "Danny" Rivera is an 8-year-old boy who comes to the clinic with a cough. Students determine if Danny is in distress, explore the underlying cause of his cough, and look for related symptoms in other body systems.

Case Highlights

-  Ask about a variety of psychosocial factors related to home life, such as second-hand smoke exposure
-  Observe non-verbal cues as Danny presents with intermittent coughing and visible breathing difficulty
-  Rule out asthma, a common childhood affliction, by examining Danny



Learning Objectives

- ☒ Perform a focused assessment of the respiratory system
 - Gather subjective and objective data
 - Select and use the appropriate tools and tests necessary for a focused exam
 - Consider and assess regional system involvement
- ☒ Differentiate between variations of normal and abnormal assessment findings to determine the cause and severity of the event.
 - Create a differential diagnosis
- ☒ Practice patient-centered care
 - Convey empathy with therapeutic communication
 - Provide patient education on condition, diagnosis, or treatment while respecting variance in health literacy
 - Express consideration and respect for patient perspectives, feelings, and sociocultural background
- ☒ Evaluate, and document patient assessment data using information systems technology
- ☒ Interview using communication techniques appropriate for a pediatric patient
- ☒ Promote patient safety, privacy, and infection control
- ☒ Communicate critical information effectively to another healthcare professional during the transfer of patient care.
- ☒ Reflect on personal strengths, limitations, beliefs, prejudices, and values

Body Systems of Study

- **Primary:** Respiratory
- **Secondary:** HEENT, Cardiovascular



Chief Complaint

"I've been coughing a lot the past four. . . no I've been coughing for five days."

Abnormal Findings

INTERVIEW

- Reports wet cough for several days
- Cough is worse at night
- Reports frequent cough as part of medical history
- Father smokes indoors
- Frequent ear infections when he was younger
- Frequent rhinorrhea
- Had pneumonia last year
- Starting to feel pain in his right ear

EXAM

- Rhinorrhea with clear mucus; inside nostril appearance red
- Increased respiratory rate
- Appears fatigued
- Nasal discharge, boggy turbinate, and visible crease on nose from rubbing
- Audible coarse crackles in upper airway; bronchovesicular on both sides, clears with cough
- Mild tachycardia
- Lymph nodes enlarged and tender on the right side
- Right ear has erythematous; canal is clear and a little red. The tympanic membrane is red and inflamed
- Fine bumps on tongue
- Tenderness in throat; "cobble stoning" in back of throat

****For instructor use****

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ADVANCED HEALTH ASSESSMENT

Cardiovascular - TINA JONES™

“I’ve noticed my heart has been beating faster than usual lately, and I thought it was something I should get checked out.



Module 4 - Cardiovascular

Over the last month, Tina has experienced 3-4 episodes of perceived rapid heart rate. She describes these episodes as “thumping in her chest” with a heart rate that is “way faster than usual”. She does not associate the rapid heart rate with a specific event, but notes that they usually occur about once per week in the morning on her commute to class. The episodes generally last between 5 and 10 minutes and resolve spontaneously. She denies chest pain during the episodes.

Timeframe: 4 months after establishing primary care (Age: 28)

Reason for visit: Patient presents complaining of recent episodes of fast heartbeat.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- **Student Performance Index** - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

R00.2, Palpitations



ADVANCED HEALTH ASSESSMENT

Cardiovascular - TINA JONES™

History of Present Illness

Ms. Jones is a pleasant 28-year-old African American woman who presented to the clinic with complaints of 3-4 episodes of rapid heart rate over the last month. She is a good historian. She describes these episodes as “thumping in her chest” with a heart rate that is “way faster than usual”. She does not associate the rapid heart rate with a specific event, but notes that they usually occur about once per week in the morning on her commute to class. The episodes generally last between 5 and 10 minutes and resolve spontaneously. She does not know her normal heart rate or her heart rate during these episodes. She denies chest pain during the episodes, but does endorse discomfort of 3/10 which she attributes to associated anxiety regarding her rapid heart rate. She denies shortness of breath. She denies any association of symptoms with exertion. She has no known cardiac history and has never had episodes prior to this last month. She has not attempted any treatment at home and states that she is only coming to the clinic today because her family has expressed concern regarding these episodes.

Subjective and Objective Model Documentation

Printable “Answer Key” available within the Shadow Health DCE.

Vitals

- Weight (kg) - 87
- BMI - 30.1
- Heart Rate (HR) - 90
- Respiratory Rate (RR) - 16
- Pulse Oximetry - 99%
- Blood Pressure (BP) - 145/90
- Blood Glucose - 140
- Temperature (F) - 98.9

Medications

- Fluticasone propionate, 110 mcg 2 puffs BID (last use: this morning)
- Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (last use: “a month ago”)
- Acetaminophen 500-1000 mg PO prn (headaches)
- Ibuprofen 600 mg PO TID prn (cramps)

Review of Systems

- General:** Denies changes in weight, but complains of end of day fatigue. She denies fevers, chills, and night sweats. She complains of intermittent dizziness.
- Cardiac:** Denies a diagnosis of hypertension, but states that she has been told her blood pressure was high in the past. She checks it at CVS periodically. At last check it was “140/80 or 90”. She denies known history of murmurs, angina, previous palpitations, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, or edema. She has never had an EKG.
- Respiratory:** She denies shortness of breath, wheezing, cough, sputum, hemoptysis, pneumonia, bronchitis, emphysema, tuberculosis. She has a history of asthma, last hospitalization was age 16 for asthma, last chest XR was age 16
- Hematologic:** She denies a history of anemia, easy bruising or bleeding, petechiae, purpura, or blood transfusions.

Chief Complaint

- Symptoms - Fast heartbeat
- Diagnosis - Palpitations

ADVANCED HEALTH ASSESSMENT

Cardiovascular - TINA JONES™

Abnormal Findings

Subjective (Reported by Tina)

- Experienced 3-4 episodes of fast heartbeat and a “thumping feeling” in the last month
- Episodes accompanied by mild anxiety
- Increased stress related to work and school
- Increased caffeine consumption from diet soda and energy drinks
- Risk factors for cardiovascular disease: type 2 diabetes, sedentary lifestyle and family history of high cholesterol and hypertension

Objective (Found by the student performing physical exam)

- Heart rate in the clinic is not tachycardic: 90 bpm
- Hypertensive blood pressure reading: 145 / 90
- Risk factor for cardiovascular disease: Obesity (BSM 31)

Assessment

Palpitations related to caffeine and/or anxiety


Plan

1. Encourage Ms. Jones to continue to monitor symptoms and log her episodes of palpitations with associated factors and bring log to next visit.
2. Obtain EKG to rule out any cardiac abnormality and assess for symptom-correlated EKG changes. If inconclusive, consider ambulatory EKG monitoring and referral to Cardiologist
3. Encourage to decrease caffeine consumption and increase intake of water and other fluids.
4. Educate on anxiety reduction strategies including deep breathing, relaxation, and guided imagery. Continue to monitor and explore the need for possible referral to social work/psychiatry or pharmacologic intervention.
5. Discuss the need to maintain a stable blood pressure. Encourage Ms. Jones to continue to monitor her blood pressure when a cuff or machine is available.
6. Educate Ms. Jones on when to seek emergent care including episodes of chest pain unrelieved by rest, palpitations that do not dissipate after anxiety related strategies were implemented, changes in vision, loss of consciousness, and sense of impending doom.
7. Revisit clinic in 24 weeks for follow up and evaluation.

FOCUSED EXAM CASE




GRADUATE - CHEST PAIN (BRIAN FOSTER™)

Introduction

 Avg. 45 min. start to finish

This assignment provides the opportunity to conduct a focused exam on a patient presenting with recent episodes of chest pain. Interview the patient, assess the related body systems, produce a differential diagnosis, and then report to your preceptor.

Case Highlights

-  Evaluate a cardiac complaint in a non-emergency setting
-  Learn about Mr. Foster's personal and family history with heart disease
-  Identify lifestyle risk factors



Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about his symptoms
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Develop strong physical assessment skills

- Select and use the appropriate procedures for a focused cardiac exam
- Differentiate between normal and abnormal assessment findings to determine the cause and severity of the event

Document accurately and appropriately

- Document subjective data using professional terminology
- Document objective data using professional terminology

Demonstrate clinical reasoning skills

- Organize all components of a focused cardiac exam
- Assess risk for disease, infection, injury, and complications
- Create a differential diagnosis

After completing the assessment, you will communicate critical information effectively to another healthcare professional, and then reflect on personal strengths, limitations, beliefs, prejudices, and values.

Body Systems of Study

- Primary: Cardiovascular
- Secondary: Respiratory, Abdominal



Chief Complaint

"I have been having some troubling chest pain in my chest now and then for the past month."

Abnormal Findings

INTERVIEW

- Reports episodes of chest pain
- Reports diagnosis of hypertension one year ago
- Reports diagnosis of hyperlipidemia one year ago

EXAM

- PMI displaced laterally
- S3 noted at mitral area
- Right side carotid bruit
- Fine crackles/rales in posterior bases of L/R lungs

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ADVANCED HEALTH ASSESSMENT

Gastrointestinal - TINA JONES™

“

I've been feeling this pain in my stomach after I eat.
It seems like it's getting a little worse all the time.

Module 5 - Gastrointestinal

For “at least a month,” Tina has been experiencing pain in her upper stomach after eating, which she describes as “kind of like heartburn, but sharper.” She notices it a little every day, but 3-4 times a week it is very painful (5/10 on pain scale). She also notices burping after she eats. She denies cough, hoarseness, sore throat, dysphagia, and chest pain.

Timeframe: 6 months after establishing primary care (Age: 28.5)

Reason for visit: Patient presents complaining of recent recurrent stomach pain.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

K21.9, gastroesophageal reflux disease without esophagitis



ADVANCED HEALTH ASSESSMENT

Gastrointestinal - TINA JONES™

History of Present Illness

Ms. Jones is a pleasant 28-year-old African American woman who presented to the clinic with complaints of upper stomach pain after eating. She noticed the pain about a month ago. She states that she experiences pain daily, but notes it to be worse 3-4 times per week. Pain is a 5/10 and is located in her upper stomach. She describes it "kind of like heartburn" but states that it can be sharper. She notes it to increase with consumption of food and specifically fast food and spicy food make pain worse. She does notice that she has increased burping after meals. She states that time generally makes the pain better, but notes that she does treat the pain "every few days" with an over the counter antacid with some relief.

Subjective and Objective Model Documentation

Printable "Answer Key" available within the Shadow Health DCE.

Vitals

- Weight (kg) - 85
- BMI - 29.4
- Heart Rate (HR) - 80
- Respiratory Rate (RR) - 15
- Pulse Oximetry - 98%
- Blood Pressure (BP) - 138/80
- Blood Glucose - 131
- Temperature (F) - 99.6

Medications

1. OTC antacid prn, last taken yesterday • Fluticasone propionate, 110 mcg 2 puffs BID (last use: this morning)
2. Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (last use: "a few months ago")
3. Acetaminophen 500/1000 mg PO prn (headaches)
4. Ibuprofen 600 mg PO TID prn (menstrual cramps: last taken a month ago)

Review of Systems

- **General:** Denies changes in weight and general fatigue. She denies fevers, chills, and night sweats.
- **Cardiac:** Denies a diagnosis of hypertension, but states that she has been told her blood pressure was high in the past. She denies known history of murmurs, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, or edema.
- **Respiratory:** She denies shortness of breath, wheezing, cough, sputum, hemoptysis, pneumonia, bronchitis, emphysema, tuberculosis. She has a history of asthma, last hospitalization was age 16, last chest XR was age 16
- **Gastrointestinal:** States that in general her appetite is unchanged, although she does note that she will occasionally experience loss of appetite in anticipation of the pain associated with eating. Denies nausea, vomiting, diarrhea, and constipation. Bowel movements are daily and generally brown in color. Denies any change in stool color, consistency, or frequency. Denies blood in stool, dark stools, or maroon stools. No blood in emesis. No known jaundice, problems with liver or spleen.

Chief Complaint

- **Symptoms** - Recurrent stomach pain
- **Diagnosis** - GERD

ADVANCED HEALTH ASSESSMENT

Gastrointestinal - TINA JONES™

Abnormal Findings

Subjective (Reported by Tina)

- Reports daily occurring stomach pain, with 3 to 4 episodes a week that are more severe
- Pain begins right after finishing a meal and lasts a few hours
- Describes the pain as similar to heartburn, located in center of upper stomach
- Pain worsens with larger or spicy meals, and with supine body position
- Decreased appetite and increased burping

Objective (Found by the student performing physical exam)

- Abdominal exam results are normal (inspection, auscultation, percussion, and palpation), which allows students to eliminate differential diagnoses such as appendicitis or cholecystitis.

Assessment

Gastroesophageal reflux disease without evidence of esophagitis

Plan

1. Educate on lifestyle changes including weight loss, engagement in daily physical activity, and limitation of foods that may aggravate symptoms including chocolate, citrus, fruits, mints, coffee, alcohol, and spicy foods.
2. Ms. Jones may elevate the head of her bed or sleep on a wedge-shaped bolster for comfort or symptom reduction.
3. Encourage to eat smaller meals and to avoid eating 2-3 hours before bedtime.
4. Educate on dietary reduction in fat to decrease symptoms.
5. Trial of ranitidine 150 mg by mouth daily for two weeks. If reduction in symptoms, Ms. Jones may continue therapy. If symptoms persist, consider testing for helicobacter pylori, trial of a proton pump inhibitor, or upper endoscopy.
6. Educate on when to seek emergent care including signs and symptoms of upper and lower gastrointestinal bleed, weight loss, and chest pain.
7. Return to clinic in two weeks for evaluation and follow up.




FOCUSED EXAM CASE

GRADUATE - ABDOMINAL PAIN (ESTHER PARK™)

Introduction

Mrs. Esther Park is a 78-year-old woman who comes to the clinic complaining of abdominal pain. She reports that the pain isn't severe, but that her daughter was concerned and brought her in. Students determine that the situation is not an emergency, and that the underlying cause of Esther's discomfort is constipation.

Case Highlights

-  Ask about a variety of psychosocial factors related to the GI system: diet, toilet habits, immunizations, recent travel, and more
-  Take a complete surgical, reproductive, and current sexual history
-  Mrs. Park verbalizes pain and winces during palpation so that students can synthesize verbal and non-verbal cues



Learning Objectives

- ☒ Perform a focused assessment of the abdominal system
 - Gather subjective and objective data
 - Select and use the appropriate tools and tests necessary for a focused exam
 - Consider and assess regional system involvement
- ☒ Differentiate between variations of normal and abnormal assessment findings to determine the cause and severity of the event.
 - Create a differential diagnosis
- ☒ Practice patient-centered care
 - Convey empathy with therapeutic communication
 - Provide patient education on condition, diagnosis, or treatment while respecting variance in health literacy
 - Express consideration and respect for patient perspectives, feelings, and sociocultural background
- ☒ Evaluate, and document patient assessment data using information systems technology
- ☒ Promote patient safety, privacy, and infection control
- ☒ Communicate critical information effectively to another healthcare professional during the transfer of patient care.
- ☒ Reflect on personal strengths, limitations, beliefs, prejudices, and values

Body Systems of Study

- **Primary:** Abdominal
- **Secondary:** Genitourinary, Cardiovascular



Chief Complaint

"I have a pain in my belly."

Abnormals

INTERVIEW

- Reports abdominal discomfort, aggravated by eating and physical activity in lower abdomen
- Reports loss of appetite, bloating, decreased fluid intake and dark urine
- Reports constipation for the past week, and diarrhea 3 days ago
- Family history of hypercholesterolemia, hypertension, DM type II, coronary artery disease, and CVA.

EXAM

- Torso: abdomen asymmetric, no redness or lesions, 10cm healed scar in suprapubic region and 6cm healed scar in RUQ noted
- Palpated LLQ with light pressure: localized distension, tenderness
- Deep palpation LLQ mild guarding and rebound tenderness; firm, oblong mass (2x4cm)
- Percussed LLQ: scatter dullness, mild guarding
- Facial expression suggests discomfort; slight flushing of cheeks; features symmetrical; mild dry skin

****For instructor use****

Focused Exam Case - G EPark v1 || Copyright © 2014 ShadowHealth.com



ADVANCED HEALTH ASSESSMENT

Musculoskeletal - TINA JONES™

“I was helping my friend Selena move into the house she just bought, and I think I tweaked my back lifting a box. I’ve been having back pain ever since.”



Module 6 - Musculoskeletal

Three days ago, Ms. Jones injured (“tweaked”) her back lifting a box. The pain is in her low back and bilateral buttocks, is a constant aching with stiffness, and does not radiate. The pain is aggravated by sitting and decreased by rest and lying flat on her back. She presents today as the pain has continued and is interfering with her activities of daily living.

Timeframe: 8 months after establishing primary care (Age: 28.5ish)

Reason for visit: Patient presents complaining of lower back pain.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

M54.5, Muscle strain in low back



ADVANCED HEALTH ASSESSMENT

Musculoskeletal - TINA JONES™

History of Present Illness

Ms. Jones presents to the clinic complaining of “horrible” back pain that began 3 days ago after she “tweaked it” while lifting a heavy box while helping a friend move. She states that she lifted several boxes before this event without incident and does not know the weight of the box that caused her pain. The pain is in her low back and bilateral buttocks, is a constant aching with stiffness, and does not radiate. The pain is aggravated by sitting (rates a 7/10) and decreased by rest and lying flat on her back (pain of 3-4/10). The pain has not changed over the past three days and she has treated with 2 over the counter ibuprofen tablets every 5-6 hours. Her current pain is a 5/10, but she states that the ibuprofen can decrease her pain to 2-3/10. She denies numbness, tingling, muscle weakness, bowel or bladder incontinence. She presents today as the pain has continued and is interfering with her activities of daily living.

Subjective and Objective Model Documentation

Printable “Answer Key” available within the Shadow Health DCE.

Vitals

- | | |
|------------------------------|--------------------------------|
| • Weight (kg) - 87 | • Pulse Oximetry - 99% |
| • BMI - 30.1 | • Blood Pressure (BP) - 141/80 |
| • Heart Rate (HR) - 88 | • Blood Glucose - 91 |
| • Respiratory Rate (RR) - 14 | • Temperature (F) - 99.2 |

Medications

- | | |
|--|--|
| 1. Ibuprofen 200 mg tablets, 1-2 tablets every 5-6 hours (last use: 5 hours ago) | 3. Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (last use: “a few months ago”) |
| 2. Fluticasone propionate 110 mcg 2 puffs BID (last use: this morning) | 4. Acetaminophen 500-1000 mg PO prn (headaches) |

Review of Systems

- **General:** Denies changes in weight, fatigue, weakness, fever, chills, and night sweats.
- **Musculoskeletal:** Denies muscle weakness, pain, joint instability, or swelling. She does state that she has difficulties with range of motion. She does state that the pain in her lower back has impacted her comfort while sleeping and sitting in class. She denies numbness, tingling, radiation, or bowel/bladder dysfunction. She denies previous musculoskeletal injuries or fractures.
- **Neurologic:** Denies loss of sensation, numbness, tingling, tremors, weakness, paralysis, fainting, blackouts, or seizures.

Chief Complaint

- **Symptoms** - Back pain
- **Diagnosis** - Muscle strain in lower back

ADVANCED HEALTH ASSESSMENT

Musculoskeletal - TINA JONES™

Abnormal Findings

Subjective (Reported by Tina)

- Reports low back pain after “tweaking it” lifting a box
- Pain and stiffness located in low back and buttocks
- Current pain rating of 5/10
- Pain is interfering with activities of daily living

Objective (Found by the student performing physical exam)

- Visible facial expression of discomfort when performing Range of Motion tests
- ROM results are normal, but Tina performs them slowly and with discomfort

Assessment

Low back muscle strain related to lifting

Plan

1. Provide Ms. Jones with materials detailing stretching techniques for the lower back.
2. Initiate treatment with ibuprofen 600 mg by mouth every six to eight hours with food as needed for pain for the next two weeks. She may use acetaminophen 500-1000 mg by mouth every 8 hours for breakthrough pain
3. Ms. Jones can also use adjunct therapy of topical heat or ice per comfort TIDQID.
4. Educate on proper body mechanics and lifting techniques.
5. Educate on when to seek emergent care including loss of bowel or bladder function, acute changes in sensation of lower extremities, or limitations in movement of lower extremities.
6. Return to clinic in two weeks for follow up and evaluation of symptoms.

ADVANCED HEALTH ASSESSMENT

Neurological- TINA JONES™

“

“I was in a fender bender a week ago and I started having headaches and neck pain a couple days later.”

Module 7 - Neurological

Two days after a minor, low-speed car accident in which Tina was a passenger, she noticed daily bilateral headaches along with neck stiffness. She reports that it hurts to move her neck, and she believes her neck might be swollen. She did not lose consciousness in the accident and denies changes in level of consciousness since that time. She states that she gets a headache every day that lasts approximately 12 hours. She occasionally takes 650 mg of over the counter Tylenol with relief of the pain.

Timeframe: 11 months after establishing primary care (Age: almost 29)

Reason for visit: Patient presents complaining of headache after a recent minor car accident.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

G44.319, Acute post-traumatic headache



ADVANCED HEALTH ASSESSMENT

Neurological- TINA JONES™

History of Present Illness

Ms. Jones presents to the clinic complaining of a headache and neck stiffness that started 2 days after she was in a minor fender bender. One week ago she states that she was a restrained passenger in an accident in a parking lot and estimates the speed to be approximately 5-10 mph. She and the driver did not seek emergent care and felt fine after the accident. Two days later, however, she developed a bilateral temporal dull ache accompanied by neck ache. She states that she feels as though her neck may be slightly swollen as well.

She did not lose consciousness in the accident and denies changes in level of consciousness since that time. She states that she gets a headache every day that lasts approximately 12 hours. She occasionally takes 650 mg of over the counter Tylenol with relief of the pain. She denies known associated symptoms.

Subjective and Objective Model Documentation

Printable "Answer Key" available within the Shadow Health DCE.

Vitals

- Weight (kg) - 88
- BMI - 30.5
- Heart Rate (HR) - 82
- Respiratory Rate (RR) - 16
- Pulse Oximetry - 99%
- Blood Pressure (BP) - 139/87
- Blood Glucose - 117
- Temperature (F) - 98.9

Medications

1. Tylenol 650 mg po, q 6 hours (last use: "this morning")
2. Fluticasone propionate 110 mcg 2 puffs BID (last use: "this morning")
3. Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (last use: "a few month ago")
4. Ibuprofen 600 mg PO TID prn (cramps)

Review of Systems

- **General:** Denies changes in weight, fatigue, weakness, fever, chills, and night sweats.
- **Head:** Denies history of trauma before this incident. Denies current headache.
- **Eyes:** She does not wear corrective lenses, but notes that her vision has been worsening over the past few years, but no acute changes. She complains of blurry vision after reading for extended periods. Denies increased tearing or itching.
- **Ears:** Denies hearing loss, tinnitus, vertigo, discharge, or earache.
- **Nose/Sinuses:** Denies rhinorrhea. Denies stuffiness, sneezing, itching, previous allergy, epistaxis, or sinus pressure.
- **Musculoskeletal:** Denies muscle weakness, pain, difficulties with range of motion, joint instability, or swelling.
- **Neurologic:** Denies loss of sensation, numbness, tingling, tremors, weakness, paralysis, fainting, blackouts, or seizures. Denies bowel or bladder dysfunction. Denies changes in concentration, sleep, coordination, appetite.

Chief Complaint

- **Symptoms** - Headache
- **Diagnosis** - Acute post-traumatic headache

ADVANCED HEALTH ASSESSMENT

Neurological- TINA JONES™

Abnormal Findings

Subjective (Reported by Tina)

- Reports recurring headaches after a fender bender 1 week ago
- Rates pain severity is 3 out of 10
- Describes pain as a dull ache in both temples
- Associated symptoms are neck stiffness and slight pain
- Pain increases with head or neck movement
- Reports history of headaches when reading

Objective (Found by the student performing physical exam)

- Testing optic nerve via visual acuity, students will find: right eye 20/40, left eye 20/20
- Testing optic nerve with ophthalmoscope, students will observe: Right fundus with sharp disc margins, cotton wool spots observed
- Testing feet with monofilament for neuropathy, students will notice decreased sensation both feet

Assessment

Acute post-traumatic headache following lowspeed MVA where Ms. Jones was a restrained passenger

Plan

1. Encourage Ms. Jones to continue to monitor symptoms and report any increase in frequency or severity of her headaches.
2. Initiate treatment with ibuprofen 800 mg by mouth every 8 hours as needed with food for the next 5 days.
3. Ms. Jones can also use adjunct therapy of topical heat or ice per comfort TIDQID.
4. Educate on mild stretches for upper back and neck.
5. Educate on when to seek emergent care including the worst headache of her life, acute changes in vision, hearing, or consciousness, episodes of nausea or vomiting associated with headache, or numbness, tingling, or paralysis of new onset.
6. Ask Ms. Jones to call the office in two days to discuss symptoms. If no decrease in symptoms, order a computerized tomography scan or magnetic resonance imaging.

ADVANCED HEALTH ASSESSMENT

Mental Health - TINA JONES™

“My sleep has been terrible lately, and I keep waking up tired. I just don't feel like myself, like kind of on edge all the time. I'm especially worried about it because I have a really important exam coming up.



Module 8 - Mental Health

Tina's recent sleep disturbance has lasted a month. She has been having disturbed sleep 4-5 nights a week. She states that her sleep is "shallow and not restful". She complains of difficulty falling asleep at least 4 or 5 nights per week, but states that she is able to stay asleep without difficulty. On average she sleeps 4 or 5 hours per night and awakens at 8:00am daily. She does not take any prescription or over the counter sleep aids.

Timeframe: 12 months after establishing primary care (Age: 29)

Reason for visit: Patient presents complaining of sleep problems and feelings of anxiety.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying Diagnoses

Sleep disturbance caused by anxiety about coming exam and job search.



ADVANCED HEALTH ASSESSMENT

Mental Health - TINA JONES™

History of Present Illness

Ms. Jones presents to the clinic complaining of difficulty sleeping which she notes to have started 1 month ago. She states that her sleep is "shallow and not restful". She complains of difficulty falling asleep at least 4 or 5 nights per week, but states that she is able to stay asleep without difficulty. On average she sleeps 4 or 5 hours per night and awakens at 8:00am daily. She states that she has a fairly consistent schedule on weekdays and weekends. She does not take any prescription or over the counter sleep aids. She limits screen time prior to bed and does not ingest caffeine after 4pm daily. She endorses decreased feelings of sleepiness over the past month. She denies difficulties awaking, but does not feel rested in the morning and has daytime fatigue (rates 5/10 severity), restlessness, and irritability (rates 2/10 severity). She does not take naps.

Subjective and Objective Model Documentation

Printable "Answer Key" available within the Shadow Health DCE.

Vitals

- | | |
|------------------------------|--------------------------------|
| • Weight (kg) - 85 | • Pulse Oximetry - 98% |
| • BMI - 29.4 | • Blood Pressure (BP) - 146/92 |
| • Heart Rate (HR) - 96 | • Blood Glucose - 190 |
| • Respiratory Rate (RR) - 18 | |

Medications

- | | |
|---|--|
| 1. Fluticasone propionate 110 mcg 2 puffs BID (last use: "this morning") | 3. Acetaminophen 500-1000 mg PO (headaches) |
| 2. Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (last use: "a few month ago") | 4. Ibuprofen 600 mg PO TID prn (menstrual cramps: last taken 2 days ago) |

Review of Systems

- **General:** Denies changes in weight, weakness, fever, chills, and night sweats. Does complain of increasing daytime fatigue.
- **Neurologic:** Denies loss of sensation, numbness, tingling, tremors, weakness, paralysis, fainting, blackouts, or seizures. Endorses changes in concentration and sleep. Denies changes or difficulties in coordination.
- **Psychiatric:** States that her mood has been "off" and she does not feel like herself. She does complain of increased anxiety related to upcoming exams and job search. She has no history of depression, but does state that she feels helpless and notes that her performance at work and school is beginning to decline. She denies tension or memory loss. No past suicide attempts. Denies suicidal or homicidal ideation.

Chief Complaint

- **Symptoms** - Unable to sleep, fatigue
- **Diagnosis** - Anxiety and sleep disturbance

ADVANCED HEALTH ASSESSMENT

Mental Health - TINA JONES™

Abnormal Findings

Subjective (Reported by Tina)

- Reports difficulty sleeping, with worry “racing thoughts” before bed
- Falling asleep takes 1+ hours, and she wakes up 2 to 3 times each night
- Sleeps an average of 4 or 5 hours a night
- Describes upcoming college graduation and need to secure employment
- Reports feeling nervous and worrying about the future
- Associated effects on mood: slight irritability, difficulty concentrating, and fatigue
- Associated effects on GI: decreased appetite, feeling “a little queasy” from lack of sleep, high cholesterol and hypertension

Objective (Found by the student performing physical exam)

- Students test memory, judgment, and abstract thought, and uncover no abnormal findings.

Plan

1. Encourage Ms. Jones to continue to monitor symptoms and log her episodes of insomnia and anxiety with associated factors and bring log to next visit.
2. Encourage to decrease caffeine consumption and increase intake of water and other fluids.
3. Educate on anxiety reduction strategies including deep breathing, relaxation, and guided imagery. Continue to monitor and explore the need for possible referral to social work/psychiatry or pharmacologic intervention.
4. Discuss need to maintain regular sleep and wake schedule and sleep hygiene techniques including limiting caffeine after 2pm, limiting fluids after dinner, limiting screen time or stimulating activities after 8pm, and to get out of bed if awakened in the middle of the night.
5. Educate to limit alcohol and depressant medications (including diphenhydramine and Tylenol PM).
6. Educate on when to seek further or emergent care including feelings of self-harm or hopelessness.
7. Revisit clinic in 24 weeks for follow up and evaluation.

ADVANCED HEALTH ASSESSMENT

Comprehensive Assessment - TINA JONES™

“

I came in because I'm required to have a recent physical exam for the health insurance at my new job.

Module 9 - Comprehensive Assessment

Ms. Jones is a pleasant, 29-year-old African American single woman who presents for a pre-employment physical. She is the primary source of the history. Ms. Jones offers information freely and without contradiction. Speech is clear and coherent. She maintains eye contact throughout the interview.

Timeframe: 18 months after establishing primary care (Age: 29.5)

Reason for visit: Patient requests a complete health assessment for a pre-employment physical.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying Diagnoses

Tina still has asthma and diabetes, but both are under control. She presents with no complaint.



ADVANCED HEALTH ASSESSMENT

Comprehensive Assessment - TINA JONES™

History of Present Illness

Ms. Jones reports that she recently obtained employment at Smith, Stevens, Stewart, Silver & Company. She needs to obtain a preemployment physical prior to initiating employment. Today she denies any acute concerns. Her last healthcare visit was 4 months ago, when she received her annual gynecological exam at Shadow Health General Clinic. Ms. Jones states that the gynecologist diagnosed her with polycystic ovarian syndrome and prescribed oral contraceptives at that visit, which she is tolerating well. She has type 2 diabetes, which she is controlling with diet, exercise, and metformin, which she just started 5 months ago. She has no medication side effects at this time. She states that she feels healthy, is taking better care of herself than in the past, and is looking forward to beginning the new job.

Subjective and Objective Model Documentation

Printable "Answer Key" available within the Shadow Health DCE.

Vitals

- Weight (kg) - 84
- BMI - 29.0
- Heart Rate (HR) - 78
- Respiratory Rate (RR) - 15
- Pulse Oximetry - 99%
- Blood Pressure (BP) - 128/82
- Blood Glucose - 100

Medications

- Fluticasone propionate 110 mcg 2 puffs BID (last use: "this morning")
- Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (last use: "a few month ago")
- Acetaminophen 500-1000 mg PO (headaches)
- Ibuprofen 600 mg PO TID prn (menstrual cramps: last taken 2 days ago)

Review of Systems

- General:** No recent or frequent illness, fatigue, fevers, chills, or night sweats. States recent 10 pound weight loss due to diet change and exercise increase.
- Skin:** Reports improved acne due to oral contraceptives. Skin on neck has stopped darkening and facial and body hair has improved. She reports a few moles but no other hair or nail changes.
- HEENT:** Reports no current headache and no history of head injury or acute visual changes. Reports no eye pain, itchy eyes, redness, or dry eyes. Wears corrective lenses. Last visit to optometrist 3 months ago. Reports no general ear problems, no change in hearing, ear pain, or discharge. Reports no change in sense of smell, sneezing, epistaxis, sinus pain or pressure, or rhinorrhea. Reports no general mouth problems, changes in taste, dry mouth, pain, sores, issues with gum, tongue, or jaw. No current dental concerns, last dental visit was 5 months ago. Reports no difficulty swallowing, sore throat, voice changes, or swollen nodes.
- Cardiovascular:** Reports no palpitations, tachycardia, easy bruising, or edema.
- Respiratory:** Reports no shortness of breath, wheezing, chest pain, dyspnea, or cough.
- Gastrointestinal:** Reports no nausea, vomiting, pain, constipation, diarrhea, or excessive flatulence. No food intolerances.
- Genitourinary:** Reports no dysuria, nocturia, polyuria, hematuria, flank pain, vaginal discharge or itching
- Breasts:** Reports no general breast problems, lumps, or pain.
- Neurologic:** Reports no dizziness, light-headedness, tingling, loss of coordination or sensation, seizures, or sense of disequilibrium.
- Musculoskeletal:** Reports no muscle pain, joint pain, muscle weakness, or swelling.
- Mental Health:** Reports decreased stress and improved coping abilities have improved previous sleep difficulties. Denies current feelings of depression, anxiety, or thoughts of suicide.

Chief Complaint

- Symptoms - No symptoms
- Diagnosis - [NONE] Pre-employment physical

ADVANCED HEALTH ASSESSMENT

Comprehensive Assessment - TINA JONES™

Abnormal Findings

[NONE] Pre-employment physical

Assessment

Tina Jones comes in for a follow-up/general physical exam. She is now on metformin, Proventil, and Flovent. She has glasses following a vision exam. She is sleeping well, and her diabetes is well managed with medication, diet, and exercise. She regularly monitors her blood sugar levels and feels more comfortable with her knowledge regarding the meaning of the readings. She has begun keeping records of her asthma by monitoring her peak flow and tracking the use of her rescue inhaler. She is in a relationship and is now on birth control, which is helping to control her PCOS.

Plan

[NONE] Pre-employment physical

Instructor Use Only