

MEDICAL SCHOOL AND RESIDENCY PROGRAM  
CURRICULUM RESOURCES ON DRUG ABUSE AND ADDICTION

Talking to Patients About Sensitive  
Topics: Communication and  
Screening Techniques for Increasing  
the Reliability of Patient Self-Report

University of North Dakota  
School of Medicine & Health Sciences

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<http://www.drugabuse.gov/coe>

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# **Talking to Patients About Sensitive Topics: Communication and Screening Techniques for Increasing the Reliability of Patient Self-Report**

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## Introduction

**Background:** Research indicates that physicians frequently do not ask patients about sensitive topics such as substance use/abuse during routine medical histories. This is often because physicians are uncomfortable broaching these topics, and/or they do not feel adequately prepared to ask questions during routine screenings about these topic areas. This module addresses these issues by providing: (a) communication techniques that decrease patient and physician anxiety and increase the accuracy and specificity of patient self-report about sensitive topics, and (b) brief, evidence-informed screening protocols related to intimate partner violence, substance use/abuse, and sexual practices, that can be easily integrated into a routine medical history (see “Educational Goals and Objectives,” pg. 5).

**Module Description:** This module on interviewing patients about sensitive subjects is geared toward first- or second-year medical students who have had prerequisite training in taking a basic medical history and in general communication skills such as active listening, paraphrasing, etc. (for an example, see “Patient History Format,” pg. 27). This module can also be integrated into a broader course about doctor-patient communication as a more advanced skill or used as a stand-alone module for diverse audiences who have had the prerequisites noted above (e.g., nurses, residents, practicing physicians, physician assistants, etc.). Although the content and screening questions for each of these sensitive topic areas are different, the communication techniques for decreasing patient anxiety and resistance and for improving the reliability of patient self-report are very similar, generalizing across many topics and contexts. The format for this product is: (a) a 1.5-to-2-hour interactive lecture using PowerPoint slides, and (b) a 2-hour clinical skills practice session using standardized patients (SPs), although time may vary depending upon the class size, number of SPs, or other logistical considerations.

- **Interactive Lecture:** Along with the PowerPoint slides, a “Lecturer Guide” (see pgs. 7–15) provides background and suggested talking points for each PowerPoint slide in the presentation. A student handout for the lecture is also included in this educational module. The student handout consists of the PowerPoint lecture slides that have been modified for use as a lecture handout. Please note that the interactive, in-class quizzes embedded in the PowerPoint lecture slides are omitted from the student handout.
- **Skills Practice Sessions:** The important components to consider for any protocol are whether it provides the: (a) the opportunity to practice the skills (e.g., use SPs or role play and practice with peers), (b) the opportunity to observe others and provide feedback, (c) the opportunity to reflect on one’s skills and receive immediate feedback on one’s performance (formative evaluation), and (d) a summative evaluation. A set of cases for training SPs (see “Supplemental Examples and Potential Resources,” pg. 24), the Medical Interviewing Checklist for providing both formative and summative evaluation (see pgs. 17–18), and instructions on giving peer feedback are included (see pg. 19).

This project was piloted during the fall session of 2008 using the PowerPoint lecture, as well as the other supporting materials and activities (see section "Pilot Information," pg. 24).

**Key words:** drug abuse; drug addiction; substance abuse; patient interviews; substance abuse screening; social history; alcohol use history; medical history; sensitive topics; sexual history; intimate partner violence; domestic violence; communication techniques; peer evaluation

## Educational Goals and Objectives

### **Goals:**

Learn (a) communication techniques that decrease patient and physician anxiety and increase the accuracy and specificity of patient self-report about sensitive topics, and (b) basic screening protocols for assessing alcohol/drug use, intimate partner violence, and sexual practices and concerns.

### **Objectives:**

Using a combined method of interactive lecture followed by skills practice sessions:

- Identify and demonstrate understanding of factors that affect the reliability and specificity of patient self-report when asked about sensitive topics.
- Identify, practice, and demonstrate understanding of specific communication techniques that increase the reliability and specificity of patient self-report when discussing sensitive topics.
- Practice and demonstrate understanding of brief, basic screening protocols (as there are multiple protocols and not one stand alone evidence-based standard) for assessing alcohol and drug use/abuse, intimate partner violence, and sexual practices that can be easily integrated into a routine medical history.

- **Curriculum Module Components**

This module includes the following resources:

- **Lecture Slides** a PowerPoint presentation titled “Talking to Patients About Sensitive Topics: Communication and Screening Techniques for Increasing the Reliability of Patient Self-Report”
- **Lecturer Guide** (accompanies the PowerPoint slides and are also included in the note section of the slide presentation)
- **Student Handout** consisting of a modified set of the PowerPoint lecture slides labeled “Student Handout” that can be printed and provided as a handout (it does not contain the lecturer notes)
- **Medical Interviewing Checklist** used by both students and preceptors during skills practice for formative and/or summative evaluation
- **Tips for Giving Peer Feedback**
- **Additional Reading**
- **Pilot Information**
- **Supplemental examples and potential resources**
  - **Learning objectives** for training in basic medical interviewing, including screening for sensitive information\*
  - Complete **Patient History Format** used as a student guide\*
  - **Three standardized patient sample cases\*\***

\*Developed and used for training basic history taking at the UND School of Medicine & Health Sciences (UNDSMHS) based on Calgary-Cambridge model.

\*\*Used for training standardized patients for the sensitive topics module at the UND School of Medicine & Health Sciences (UNDSMHS).

## Lecturer Guide (for use with PowerPoint lecture slides)

### Slide 1: Title

Introductory comments could include the following:

- This lecture about sensitive topics adds to your history-taking skill set by adding key questions, typically asked during the social history, to screen patients for information about sensitive topic areas.
- This lecture also introduces some techniques that enhance your ability to communicate with patients about sensitive issues.
- Many times the focus of a medical interview is related to “what” to ask. However, the “how” of asking questions:
  - how to preface them
  - how to word them
  - how to order the questions

is especially important when asking about sensitive topics.

- Success in taking a medical history of sensitive topics depends on three things:
  1. Putting yourself and the patient at ease.
  2. Using carefully worded questions.
  3. Using brief, evidence-informed procedures or protocols for screening sensitive topic areas. The sensitive topic areas that are introduced in this lecture are important parts of any routine medical history. Yet, these important questions are often omitted because physicians do not feel adequately prepared to ask about these areas and/or their anxiety or the patient’s anxiety presents a barrier to asking the questions.

### Slides 2 and 3:

Introduce the three sensitive topic areas that are included in the lecture: substance use and abuse; intimate partner violence (IPV); and sexual practices and concerns.

Emphasize that a focus of the lecture and skills training is on brief **SCREENING** of these topic areas as part of learning to take a medical history. In other words, what are the screening protocols for inquiry about these topics?

You may note that there are other sensitive topic (Slide 3) areas not covered in this lecture, but that the communication techniques the students will be learning and practicing can also be used for discussing these areas.

**IMPORTANT TO NOTE:** Emphasize that this lecture is **NOT** an in-depth discussion of these topic areas from a content perspective, nor is it a lecture about what to do with a positive screen. The focus of this lecture is on how to broach these sensitive topic areas with patients, and how to **SCREEN** for problems. **What to do with a positive screen** is a different skill set that should be taught separately, along with specific training in the in-depth content related to these topics. Please emphasize for students that knowing what to do with a positive screen has a direct impact on their comfort and confidence levels in performing the screen but that the purpose here is to focus on techniques for including **these screening questions when taking routine medical histories.** There are well-documented approaches on how to conduct brief interventions and how to teach brief

intervention techniques that can be used to teach a follow-up or companion course to this resource.

For more information on substance abuse screening, please see other curriculum resources offered by the National Institute on Drug Abuse (NIDA) Centers of Excellence (CoE) for Physician Information available at <http://www.drugabuse.gov/coe/>. These innovative drug abuse and addiction curriculum resources help physicians identify patient drug use early and prevent it from escalating to abuse or addiction.

**Slide 4: Objective 1 for the lecture**

Identify and demonstrate understanding of factors that affect the reliability and validity of patient self-report when asked about sensitive topics

**Slide 5: Objective 2 for the lecture (and accompanying skills practice activity)**

Identify, demonstrate understanding of, and practice specific communication techniques that increase the reliability and validity of patient self-report.

**Slide 6: Objective 3 for the lecture (and accompanying skills practice activity)**

Demonstrate understanding of and practice basic screening procedures for alcohol/drug use, intimate partner violence, and sexual activities and concerns as well as approaches to use if a presenting problem is a sensitive topic, such as a sexual problem.

**Slide 7: Transition slide for Objective 1**

**Slide 8: Overview slide for Objective 1**

Three important factors that could affect reliability and validity of patient self-report (Aira, Kauhanen, Larivaara, & Rautio, 2002; Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education, 2001; Frankel, Williams, & Edwardsen, 2003; Frankel & Stein, 1999; Kurtz, 2002; Kurtz, Silverman, Benson, & Draper, 2003; Sankar & Jones, 2005; Shea, 1998; Shea & Barney, 2007; Shea, Barney, & Lapetina, 2007):

- Your own anxiety to talk about certain topics
- The patient's anxiety to talk about certain topics
- The "how" of asking questions

**Slide 9: Objective 1, Factor 1**

Your own anxiety when talking about certain subjects. For this slide ask the students what might be the cause of their anxiety to talk about a topic such as drug use or sexual practices. Also, ask how their anxiety could affect the information obtained during a routine medical history. Answer: It may result in avoidance of inquiry about these topics.

**Slide 10: Objective 1, Factor 2**

The patient's anxiety to talk about certain topics. Present each point and consider asking students for examples and/or feedback.

**Slide 11: Objective 1, Factor 3**

How questions are asked. The wording of questions—asking for specific data rather than opinions; the order of questions—the order of questions for screening procedures; and the form of questions—the use of open- vs. close-ended questions, can all affect the accuracy of the information obtained.

**Slide 12: Transition slide for Objective 2**

**Slide 13: Summary slide for Objective 2, listing two types of approaches for improving the accuracy of patient self report.**

Two techniques that improve reliability by decreasing anxiety:

**Preparing the patient** (and physician) or setting the context to answer (and ask) questions about sensitive topics

**Careful, mindful wording** of questions that will help to minimize anxiety because they increase the clarity of the information needed, thereby minimizing ambiguity for the patient as to what information to share

Asking for facts/asking for specifics is a special subsection of methods that increase accuracy and reliability (see notes for slides 30–37 below for a more detailed description). These techniques are more general and not particularly techniques that decrease anxiety, but rather address the reliability issue.

**Slide 14:**

Lists the different communication techniques for decreasing anxiety by setting the stage of preparing the patient to discuss sensitive topics.

**Slide 15:**

Covers NORMALIZING—a technique for decreasing anxiety by making the problem or the anxiety a somewhat universal experience. The slide gives some examples of this technique.

**Slide 16:**

Covers the technique of using TRANSPARENCY when preparing to ask questions—telling the patient why you need to ask about certain information. This decreases patients' concerns about how the questions are relevant to their care.

**Slide 17:**

Covers the technique of ASKING THE PATIENT'S PERMISSION when inquiring about certain topics.

**Slide 18:**

Covers the technique of giving the patient the OPTION OF NOT ANSWERING particular questions.

**Slide 19:**

Embedded Fill-in-the-Blank Quiz. Students are asked to name the techniques that are demonstrated in the following statements:

- “I ask all my patients about their sexual activity as part of gaining their medical history” (NORMALIZING [universality statement]) because it can have an important impact on their overall health. (TRANSPARENCY) Would it be OK if I asked you some questions about your sexual activities?” (ASKING PERMISSION)

**Slides 20–22:**

Note some of the issues related to confidentiality that can be discussed with a patient who has concerns. Most HIPAA agreements now have many of these points listed as a basis for certain situations that require exceptions to confidentiality. [Note: Would be helpful if facilitators can briefly note their state's applicable laws and regulations.]

**Slide 23:**

Lists different communication techniques for decreasing anxiety by wording questions to decrease ambiguity and uncertainty for the patient.

**Slide 24:**

Covers CLOSE-ENDED QUESTIONS. Although students are frequently encouraged to use open-ended questions during medical interviews, this is not effective when talking about sensitive topics—it increases ambiguity and uncertainty for the patient about how to respond. Close-ended questions decrease this ambiguity. The lecturer might ask the students to contrast these examples with some examples of open-ended questions so they can better understand how that might increase anxiety.

**Slide 25:**

Covers the technique of offering RESPONSE CHOICES—a form of close-ended question that even further decreases ambiguity for the patient about how to respond. This is an excellent technique for very sensitive topics. Some examples are provided.

**Slide 26:**

Notes the importance of CAREFUL WORD CHOICE and gives some examples of what that means.

**Slides 27 and 28:**

Covers the technique of “gentle assumption” (see Shea, 1998): ASSUMING A BEHAVIOR IS ALREADY OCCURRING. This is really another form of a “normalizing” statement because it sends the message that a particular behavior or condition is not unusual and it increases the probability that a patient will feel more at ease discussing it. Slide 28 cautions the use of leading questions—students are typically encouraged not to ask leading questions, but for these circumstances, it can be both useful and warranted. It is important to emphasize, however, that in persons who are highly suggestible, including those with cognitive deficits or in children (this is a subjective judgment, but a clinician needs to be alert to this possibility) leading questions can result in unreliable information.

**Slide 29:**

Summary slide for the techniques that improve reliability by decreasing anxiety—organized by preparing the patient techniques and by careful wording and form techniques.

**Slide 30:**

Begins a sub-section about communication techniques that can improve the quality and specificity of the data reported by the patient by **how** questions are worded.

**Slide 31:**

Outlines and names two techniques for increasing reliability of patient self-report that will be covered next: ASKING FOR FACTS NOT JUDGMENTS and DENIAL OF THE SPECIFIC (see Shea, 1998).

**Slides 32 and 33:**

Give examples of asking for facts rather than judgments or opinions. (Note: Animation is set to show the “better” way of asking questions by clicking—this way, the lecturer can ask the students to identify how they could ask these questions.)

**Slide 34:**

Identifies why it is best to avoid asking for judgments/opinions. It is of note that asking for judgments and opinions can be a very useful tool for getting the patient’s perspective or frame of reference for some things like what a patient considers “drinking too much.” However, this is a very different question, and if the interviewer is hoping to gain specific data about alcohol use, it is better to ask specific questions about the specific amount of alcohol the patient consumes.

**Slide 35:**

Embedded Quiz. Ask the students to think of ways to ask for this information that yields facts rather than judgments.

**Question 1.** Better: What specific health problems does your mother have, if any?

**Question 2.** Better: How much of the time do you use condoms: always, sometimes, never (response choice method)

**Question 3.** Better: How many times a day have you been having bowel movements?

**Question 4.** Better: How many hours do you sleep at night? Do you have trouble going to sleep/staying asleep/waking too early (ask each separately)?

**Slide 36:**

Introduces a second technique to use that increases reliability and accuracy of information: It is more difficult to deny a behavior in response to a specific question than it is to a general question.

**Slide 37:**

Gives examples of specific vs. general questions.

**Slide 38:**

Embedded Quiz: Ask students to name the strengths and/or weaknesses of each question, and at the end, which question is the best way to ask about marijuana use.

- **Question 1:** Weaknesses: it is open ended, it is general rather than specific
- **Question 2:** Weakness: it is general rather than specific by the use of “street drugs” rather than marijuana; Strengths: it asks for a specific piece of data about the **last time** the patient used; it is close ended; it uses gentle assumption
- **Question 3.** (BEST) It asks about a specific drug, asks for facts, is close-ended, and uses gentle assumption.
- **Question 4.** Weaknesses: It is open ended; Strength: uses gentle assumption; it is specific to the use of marijuana.

**Slide 39:**

Embedded Quiz: Ask students to name the strengths and/or weaknesses of each question, and at the end, which question is the best way to ask about condom use.

- **Question 1.** Weaknesses: It is open ended, which will increase anxiety, and further you may be more likely to get judgments rather than facts. Strengths: Uses gentle assumption to decrease anxiety and normalize the behavior

- **Question 2.** (BEST) Strength: It is close ended, uses response choice, uses gentle assumption, asks for a fact, and is specific (versus: “Do you use ‘protection’ or ‘birth control?’”).
- **Question 3.** Weaknesses: It asks for judgment or opinion, not facts—namely, the patient determines what “usually” means.
- **Question 4.** Not the best because: There are ways to decrease anxiety about such a question, such as response choice and gentle assumption; it does not tell you how much of the time the person uses condoms. Strengths are that it is close-ended and specific.

**Slide 40:**

Embedded Quiz: Ask the students to develop questions and to name the techniques used and the rationale for using each technique.

**Slide 41: Transition slide for Objective 3**

Transition slide introducing the third learning objective: Learn and understand screening procedures for substance use, intimate partner violence (IPV), and sexual practices and concerns as well as how to approach a patient with a presenting problem that involves sensitive issues.

**Slide 42:**

Presents a general organizational format to use when screening about all three topic areas.

**Slide 43: Objective 3, Topic 1: Alcohol, Street Drugs, and Prescription Drug Misuse**

Procedures for screening for alcohol, street drugs, and prescription drug misuse.

**Slide 44:**

Suggests that alcohol and substance use/abuse screening often occurs during the assessment of lifestyle behaviors in the social history.

**Slides 45–49:**

Provide a stepped approach for assessing a patient’s current alcohol use that incorporates recommendations for screening from NIAAA, NIDA, and World Health Organization ASSIST Project. Users of this product may choose to modify specific aspects of this protocol, but the authors believe this protocol reflects some of the best practices in the most succinct format.

**Slide 45:**

Describes the first three questions asked for a screening of alcohol use. Emphasize with the students that the WORDING IS IMPORTANT (e.g., using the format “Have you EVER used alcohol?”) and that the order of the questions is also important. Because this is screening CURRENT use patterns, if the patient answers that they have not used in the last year, ask the third question about past use but discontinue steps 2 and 3 of the screening for current use.

**Slide 46:**

Describes Step 2: QUANTIFYING USAGE

- How many days per week do you drink?

- On a typical day when you drink, how many drinks do you have?
- What is the maximum number of drinks you had on any single occasion in the past month?

Again, note that the wording and order of questions is important and that consistency of use will increase an interviewer's ease in asking these screening questions when obtaining medical histories.

**Slide 47:**

This slide relates to Step 2 by defining risky alcohol use.

**Slides 48 and 49:**

Step 3: Screen for dependency and potential substance use disorder

Two potential methods are provided for dependency screening: CAGE and Two-Item Screen. [The user of the product may choose to incorporate alternative dependency screening questions and protocols.]

**Slides 50 and 51:**

These slides are included for informational purposes because ASSIST is a tool students may see in the future. In addition, the National Institute on Drug Abuse (NIDA) offers the NIDA-Modified ASSIST, a Web-based interactive tool that guides clinicians through a short series of screening questions, generating a substance involvement score that suggests the level of intervention needed. The NM ASSIST is available from NIDA online at: <http://ww1.drugabuse.gov/nmassist/>

**Slide 52:**

Summary of alcohol screening procedure.

**Slide 53:**

Identifies and names commonly used street drugs that students should ask about in their screenings.

**Slides 54 and 55:**

Procedure for screening for street drug use, which uses the same format as alcohol screening.

**Slides 56 and 57:**

Some general cues suggesting alcohol and/or drug abuse.

**Slide 58: Objective 3, Topic 2: Intimate Partner Violence**

Procedures for screening for intimate partner violence (IPV).

**Slides 59 and 60:**

Some facts about IPV. Although not a lecture about content, these slides are included to make the point that IPV is a widespread problem worthy of attention during routine medical visits. Bring up issue of whether or not the students would inquire about this with their male patients.

**Slides 61–63:**

Examples of two formal screening methods for IPV: SAFE and PARTNER VIOLENCE SCREEN (PVS) [for review of screening tools, see MacMillan, Wathen, Jamieson, Boyle, McNutt, Worster, ... Webb, M. (McMaster Violence Against Women Research Group),

2006]. Note that other formal screening methods exist. Both screenings shown here ask the two most important questions: “Have you ever been afraid of your current partner?” and “Have you ever been afraid of a past partner?” As a brief screen, these two questions, at a minimum, should be asked during the medical history.

**Slides 64 and 65:**

The two of the most important signs of intimate partner violence. As the literature indicates, fear of a current or of a past partner are the most reliable indicators of abuse—even beyond the physical exam (MacMillan et al., 2006). At a minimum these two questions, one about each of these areas, are important to ask during a routine medical history. (The user of this product may wish to incorporate alternative screening protocols as there are many available, but some form of these two questions are included in all of them.)

**Slides 66: Objective 3, Topic 3: Sexual Practices and Concerns**

Procedures for sexual practices and concerns.

**Slide 67:**

Introductory slide for screening for sexual practices and concerns as well as how to approach a patient with a presenting problem that involves a sensitive topic. (The protocol included in this product reflects key questions recommended by different experts in this area, although there is not one single stand-alone protocol at this point in time. The user of this product may wish to modify the screening protocol depending upon their interpretation of the information in the literature in this area.)

**Slides 68 and 69:**

General tips about communication related to sexual topics.

**Slide 70:**

Embedded Quiz: Reviewing communication strategies used to reduce anxiety.  
Answers to first example: transparency, normalizing, and permission.  
Answers to second example: Normalizing (in this case, normalizing the anxiety of discussing the topic)

**Slide 71:**

Examples of introductory statements used to preface discussion about sexual topics.

**Slides 72–75:**

General format for screening about sexual activity/practices and sexual concerns.

**Slides 76–79:**

Covers: “What if the presenting problem is a sexual problem?” *Answer:* Take steps to put the patient at ease, as many patients feel embarrassed or uncomfortable talking about these problems. Other than taking these preparatory steps (noted on slides 78 and 79), the physician would ask the same types of questions as for any history of presenting illness (HPI)—a truncated example is provided on slide 79.

**Slide 80:**

Summary slide for screening and discussion of sexual topics.

**Slide 81: Sensitive Topics Quiz****Slides 82–95:**

Embedded Quiz for students that covers the entire lecture. In several pilots of this product, some questions are repeated. The students found it helpful to try one time and then be quizzed again on the same material immediately afterward. The user may or may not wish to proceed in this manner. Answers are provided in PowerPoint Notes View.

**Slides 96–98:**

Final summary of the lecture objectives. Note that the next step is to practice the skills.

**Slide 99:**

Note that reflection about your own feelings is important. As noted previously, anxiety can prevent you from asking certain emotionally charged questions and, therefore, prevent you from getting a thorough patient history.

**Slides 100 and 101:**

Informational Web sites.

## Skills Practice

As a part of basic communication skills training, students complete medical interviews on standardized patients (SPs). This activity is performed in small groups (seven or eight students), along with a faculty facilitator who is an M.D. or a Ph.D. clinical psychologist. Students take turns interviewing the SPs while the rest of the group observes.

Prior to the session, provide students with the handout on giving feedback as well as the Medical Interviewing Checklist so they can familiarize themselves with this information. The instructor might also consider having some discussion about using the Checklist and about giving feedback.

During the practice session, have students take turns playing the role of a physician who is taking a 20- to 30-minute medical history of an SP. While one student conducts an interview with an SP, have the other medical students in the group and preceptor observe the interview and complete a Medical Interviewing Checklist (see pgs. 16–17), which serves as a formative evaluation tool for both observers and interviewees.

Following the interview:

- The SP gives verbal feedback to the interviewer/group,
- The student interviewer provides a verbal self-evaluation,
- Students and the facilitator provide verbal feedback to the interviewer, and
- Selected students and the facilitator provide written feedback to the interviewer using the Medical Interviewing Checklist (see the following pages).

This process is considered an evaluation of this material and is the skills-practice component of the module. Students receive a summative evaluation during a clinical skills exam that includes the same material as is included on the formative evaluation. The sensitive topic areas of the medical interview and in this module are **highlighted in orange**.

### Evaluation Tool: The Medical Interviewing Checklist

The following form can be used in the manner described here or modified to fit the needs of the training program (e.g., training just about the sensitive topic screenings).

The Medical Interviewing Checklist					
<b>Interviewer: Observer</b>					
Domain	Observed	Comments	Domain	Observed	Comments
<b>Initiating the Session</b>			<b>Rapport-building and Communication Skills</b>		
Preparation			Listens attentively without interrupting, leaving time for patient to think or go on after pausing		
Introduces self					
Greets patient; inquires how patient want to be addressed (Mr., Dr., first name)					
Attends to patient's comfort					
Verifies demographic chart information					
<b>Chief Complaint (CC)</b>			Facilitates patient responses verbally (encouragement, repetition, paraphrasing, interpretation) and non-verbally (silence, nodding to convey attentiveness and understanding)		
Inquires about CC			Picks up verbal and nonverbal cues; checks these out and acknowledges as appropriate (body language, speech rate/tone, facial expression, affect, posture)		
Uses open-ended question for eliciting CC					
Listens attentively to CC without interrupting					
Asks one more open-ended question and uses facilitative responses					
Confirms patient problem list by summarizing the patient's CC ("So that's pain in your stomach and nausea...")					
Screens for further problems ("Is there anything else?")					
If appropriate, negotiates an agenda for gathering information (prioritize problems, "Which would you like to discuss? Which is of greatest concern?")			Clarifies patient statements (e.g., "Could you explain what you mean by lightheaded?")		
<b>Gathering Information: History of Presenting Illness (HPI) (disease, biomedical perspective)</b>			Prepares patient for next step (e.g., "Now I'm going to ask you some questions about...; Now I am going to examine your nose and throat; Now I am going to press on your stomach")		
Location of problem if appropriate (e.g., pain, site of injury)			Invites patient to correct, clarify, or ask questions at any point		
Onset of problem ("When did it start?" "Was it abrupt or insidious?")					
Character of problem (e.g., if pain-related, "Is it burning, sharp, stabbing, aching, radiating?" Ask for details about the problem ("What color and consistency are your stools?")					
Associated symptoms					
Aggravating factors ("Anything make it worse?")					
Alleviating factors ("Anything make it better?")					
Timing of problem (e.g., "Is it worse in the morning?")					
Environment (e.g., setting during onset of problem; "What were you doing when this started?" "Where were you when this started?")					
Severity of problem (if pain, "Can you rate your pain on a scale of 1 to 10, with one being no pain and 10 being the worse pain ever experienced")					
Similar problems in the past					
Encourage the patient to correct/clarify					
Summarize HPI					
<b>Eliciting Patient's Perspective of the Problem: Illness Perspective</b>				Shows empathy, concern, and respect for patient, his/her feelings, and his/her perceptions and concerns about illness	
<b>Ideas and beliefs</b> about problem ("Do you have any ideas about what might be going on?")			Appropriate facial expression		
<b>Concerns and feelings</b> about problem			Uses language the patient can understand		
<b>Expectations</b> about problem and visit			Encourages patient to tell his/her story of the problem from when it first started until the present		
<b>Impact</b> of problem on patient's life (e.g., can't work; can't go up stairs)			Good eye contact		
<b>Closing/transitional tasks</b>			Uses open- and close-ended questioning technique, moving from open to closed		
Provides <b>overall summary of HPI</b> , including patient perspective factors			Prepares patient to discuss sensitive topics		

Domain	Observed	Comments	
<b>Past Medical History (PMH)</b>			<b>Any additional comments</b>
Asks about overall health			
Other current/active medical problems			
Current prescription medications			
<b>Medication name</b>			
<b>Effectiveness</b>			
<b>Dosage</b>			
<b>Indication</b>			
<b>Clinician prescriber</b>			
<b>Adverse effects</b>			
<b>Timing</b>			
Non-prescription medication/supplements (name, dose, indication) effectiveness)			
Serious illnesses: what, when, outcome			
Hospitalizations: when, where, why, who (attending physician), outcome			
Surgeries: when, where, why, who (attending physician) outcome			
Serious injuries/trauma: what, when, outcome			
Reproductive history for women (obstetric history)			
Childhood illnesses			
Allergies			
If yes, what was the allergic reaction			
Immunizations: typically, tetanus, influenza, pneumonia, hepatitis			
Health screening (routine screenings such as Pap, breast exam, prostate, cholesterol, blood pressure, blood glucose levels)			
Personal safety practices (e.g., seat belts, helmets, storage of firearms)			
<b>Family History (FH)</b>			
Parents alive/deceased, health, illnesses			
Siblings " "			
Children " "			
Grandparents (if appropriate) "" "			
Diseases common in family (e.g., heart disease, cancer diabetes, depression)			
Specific familial conditions relating to current illness (e.g., "Does anyone else in the family have the flu?")			
<b>Patient Profile (PP) or Social History (SH)</b>			<b>PP or SH (Continued)</b>
Demographics, cultural background/issues			Current family and living situation
Occupation: risks, exposures, stress			Intimate partner violence (Afraid of current/past partner)
Education			Family of origin; upbringing
Lifestyle: <b>Nutrition</b> (e.g., "What do you eat on a typical day?")			Support system
Lifestyle: <b>Exercise</b> (e.g., "How much do you exercise in a typical week?")			Sexual history (e.g., "Sexually active? STD precautions; history of STDs; contraception issues; age of first intercourse (females)")
Lifestyle: <b>Tobacco</b> (e.g., "Have you ever used tobacco? In last year? How much?") Past usage, amount, years of use, attempts to quit			Sexual concerns (e.g., "Any sexual concerns?")
Lifestyle: <b>Alcohol</b> (e.g., "Ever used?" "In the last year?" "# days/week; typical # drinks; most ever used on one occasion in last month"; <b>CAGE ?s</b> if appropriate)			Spirituality (e.g., "Any spiritual concerns?")
Lifestyle: <b>Street drugs</b> (ask about each one; same sequence as for alcohol)			Summarizes and encourages patient to clarify information/ask questions
Lifestyle: <b>Hobbies</b>			Prepares patient for next step

## Tips for Giving Peer Feedback

You will be asked to give **formative feedback** to your peers following their interviews on standardized patients. Formative feedback is different from summative feedback—an example of summative feedback is a grade on a test. Formative feedback is feedback about performance that is intended as a way to enhance a learner’s ability to modify and improve behavior and performance over time with practice.

The following are some general guidelines for giving formative feedback in a group setting.

### ***Establish a group environment in which it is safe to hear and give honest feedback***

Perfection is not a requirement when practicing your interviewing skills

Think of yourselves as allies in learning—you are here to help each other learn and to improve your skills

Maintain group confidentiality—what happens in the group, stays in the group

### ***Be descriptive/constructive rather than evaluative in your comments***

Descriptive: “When you did/said [specific behavior]...I was [pleased, impressed, concerned, etc] because...” (Describes what was observed without evaluation of “good” or “bad”; “right” or “wrong”—strive for neutral play-by-play type observational feedback)

Evaluative: “You did a good job.” (Evaluates as “good”)

### ***Be specific and avoid generalizations—generalizations are not helpful to the learner in terms of improving his/her performance because they do not describe modifiable behaviors***

Specific (and descriptive): “When you did/said [specific behavior]...I was [pleased, impressed, concerned, etc] because...” (Names a specific modifiable behavior.)

General (and evaluative): “You did a good job.” (Does not name a specific modifiable behavior)

### ***Place the greatest emphasis on what went well and be specific and descriptive***

***When giving critical feedback***, be specific and phrase as something one could consider doing differently rather than “better”—the latter of which is evaluative, and then offer some possible alternative techniques or approaches. This allows the one being evaluated to reflect on whether or not he/she will choose to modify the behavior in the future.

### ***The sandwich technique: Begin and end feedback with what went well and give feedback on what could be done differently in between the two***

Positive feedback: “I was [pleased, impressed, etc] when you did/said [specific behavior] because....”

Constructive feedback: "I was [concerned, etc.] when you did/said [specific behavior] because...."

Positive feedback: "I was [pleased, impressed, etc] when you did/said [specific behavior] because...."

***Focus on specific, modifiable behavior and not personality***

***It is best to begin the feedback session with the interviewee self-assessing, starting with what he/she thinks went well followed by group feedback about what went well; and second, things he/she feels could be improved followed with group feedback about what could be done differently with both interviewee and the group offering some alternatives.***

## Additional Reading

- Aira, M., Kauhanen, J., Larivaara, P., & Rautio, P. (2002). Factors influencing inquiry about patients' alcohol consumption by primary health care physicians: qualitative semi-structured interview study. *Family Practice, 20*(30):270–275.
- American Academy of Family Physicians. Violence (Position Paper). Retrieved September 7, 2010, from <http://www.aafp.org/online/en/home/policy/policies/v/violencepositionpaper.html>
- American Medical Association. Violence Prevention—AMA Reports and Policies. Retrieved August 30, 2010, from <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/violence-prevention/ama-reports-policies.shtml>
- Association for Medical Education and Research in Substance Abuse (AMERSA) Web site. Retrieved August 24, 2009, from <http://www.amersa.org>.
- Babor, T.F., Sciamanna, C.N., & Pronk, N.P. (2004). Assessing multiple risk behaviors in primary care: Screening issues and related concepts. *American Journal of Preventive Medicine, 27*(2S):42–53.
- Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education. (2001). Essential elements of communication in medical encounters: The Kalamazoo consensus statement. *Academic Medicine, 76*(4):390–393.
- Coops, E.J., Gaba, A., & Orleans, T. (2004). Physician screening for multiple behavioral health risk factors. *American Journal of Preventive Medicine, 27*(2S):34–41.
- Clark, W.D. (2003). Alcohol and substance use. In M.D. Feldman and J.F. Christensen (Eds.), *Behavioral medicine in primary care: A practical guide* (2nd ed). New York: Lange Medical Books/McGraw Hill.
- Duffy, F.D., Gordon, G.H., Whelan, G., Cole-Kelly, K., Frankel, R., Buffone, N., ... Participants in the American Academy on Physician and Patient's Conference on Education and Evaluation of Competence in Communication and Interpersonal Skills. (2004). Assessing competence in communication and interpersonal skills: The Kalamazoo II Report. *Academic Medicine, 79*(6):495–507.
- Eisenstat, S.A., & Bancroft, L. (1999). Domestic violence. *New England Journal of Medicine, 341*:886–892.
- Floyd, M., Lang, F., Beine, K.L., & McCord, E. (2007). Evaluating interviewing techniques for the sexual history. *Archives of Family Medicine, 8*(May/June):218–223.
- Frankel, R.M., & Stein, T. (1999). Getting the most out of the clinical encounter: The Four Habits Model. *The Permanente Journal, 3*(3):79–88.
- Frankel, R.M., Williams, S., & Edwardsen, E.A. (2003). Sexual issues and professional development: A challenge for medical education. In M.D. Feldman & J.F. Christensen (Eds.). *Behavioral medicine in primary care: A practical guide* (2nd ed). New York: Lange Medical Books/McGraw Hill.

- Kim, T.W., Samet, J.H., Cheng, D.M., Winter, M.R., Safran, D.G., & Saitz, R. (2007). Primary care quality and addiction severity: A prospective cohort study. *HSR: Health Services Research, 42*(2):755–772.
- Kurtz, S.M. (2002). Doctor-patient communication: principles and practices. *Canadian Journal of Neurological Science, 29*(Suppl. 2):S2–S23.
- Kurtz, S., Silverman, J., Benson, J., & Draper, J. (2003). Marrying content and process in clinical method teaching: Enhancing the Calgary-Cambridge Guides. *Academic Medicine, 78*(8):802–809.
- MacMillan, H.L., Wathen, C.N., Jamieson, E., Boyle, M., McNutt, L.A., Worster, A., ... Webb, M. (McMaster Violence Against Women Research Group). (2006). Approaches to screening for intimate partner violence in health care settings: A randomized trial. *JAMA, 296*(5):530–536.
- Miller, W.R., Baca, C., Compton, W.M., Ernst, D., Manuel, J.K., Pringle, B., ...Zwebnen, A. (2006). Addressing substance abuse in health care settings. *Alcoholism: Clinical and Experimental Research, 30*(2):292–302.
- McNutt, L.A., Carlson, B.E., Gagen, D., & Winterbauer, N. (1999). Domestic violence screening in primary care: Perspectives and experiences of patients and battered women. *JAMWA, 54*(2):85–90.
- National Coalition Against Domestic Violence Web site. <http://www.ncadv.org>. Accessed August 24, 2009.
- National Institute of Justice and the Centers for Disease Control and Prevention. (2000). *Full report of the prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey*. Washington, DC: U.S. Department of Justice.
- National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2005). Helping patients who drink too much: A clinician's guide, updated 2005 edition. Bethesda, Md: National Institutes on Alcohol Health.
- National Institute on Alcohol Abuse and Alcoholism (NIAAA) Web site. <http://www.niaaa.nih.gov>. Accessed August 23, 2010.
- NIDAMED: Resources for Health and Medical Professionals. National Institute on Drug Abuse (NIDA) Web site. <http://www.drugabuse.gov/nidamed/>. Accessed August 23, 2010.
- Sankar, P., & Jones, N.L. (2005). To tell or not to tell. *Archives of Internal Medicine, 165*(Nov): 2378–2383.
- Schirmer, J.M., Mauksch, L., Lange, F., Marvel, M.K., Zoppi, K, Epstein, R.M., ... Pryzbylski, M. (2005). Assessing communication competence: A review of current tools. *Family Medicine, 37*(3):184–192.

Shea, S.C. (1998). The chronological assessment of suicide events: A practical interviewing strategy for the elicitation of suicidal ideation. *Journal of Clinical Psychiatry, 59*(Suppl 20): 58–72.

Shea, S.C., & Barney, C. (2007). Macrotraining: A “how-to” primer for using serial role-playing to train complex clinical interviewing tasks such as suicide assessment. *Psychiatric Clinics of North America, 30*:e1–e29.

Shea, S.C., Barney, C., & Lapetina, G. (2007). Designing clinical interviewing training courses for psychiatric residents: A practical primer for interviewing mentors. *Psychiatric Clinics of North America 30*:283–314.

Substance Abuse and Mental Health Services Administration (SAMHSA) Web site.  
<http://www.samhsa.gov>. Accessed August 23, 2010.

U.S. Preventative Services Task Force. (2004). Screening and behavioral counseling interventions in primary care to reduce alcohol misuse. Retrieved August 30, 2010, from, <http://www.uspreventiveservicestaskforce.org/uspstf/uspdrin.htm>

World Health Organization. (n.d.) Alcohol, Smoking, and Substance Involvement Screening Test (WHO–ASSIST Project). Retrieved August 23, 2009, from [http://www.who.int/substance\\_abuse/activities/assist/en/index.html](http://www.who.int/substance_abuse/activities/assist/en/index.html)

## Pilot Information

This module was piloted using 63 first-year medical students during the first 8 weeks of the first year. Students attended a 2-hour lecture focused on talking to patients about sensitive topics, which also included video demonstrations.\* Students then participated in faculty-facilitated, small-group interviewing with standardized patients (SPs). Three students in each group took turns interviewing the SPs, with each interview lasting 20 to 30 minutes and consisting of a complete medical history—including the screenings indicated above. (Students had previous instruction and practice taking a basic medical history and using basic interviewing skills.)

Following the interview, each interviewer provided a verbal self-evaluation. The interviewer received verbal feedback from the SP, peers, and faculty facilitator, and received written feedback from peers and the faculty facilitator.

### Preliminary Results of the Pilot

- Students were able to learn and effectively apply communication techniques and screening protocols.
- Course developers felt that more faculty development was needed for this specialized topic area.
- Students needed additional emphasis on and reminders about the importance of how to ask questions (the wording and sequence) and not just the fact that they needed to ask about the topic area.
- Students did well with use of communication techniques for decreasing patient anxiety.
- Students and SPs indicated there was, perhaps, some overuse of “preparatory statements,” which seemed unnatural at times. However, the statements were necessary to emphasize the use of many different approaches for decreasing patient anxiety.
- Course developers felt this module might be better placed later in the year, with the first part of the year focusing on basic interviewing skills.
- Students all passed a clinical skills exam at the end of the block that included the skills covered in this training module on sensitive topics.

\* The piloted module included a video demonstration of screening for IPV, alcohol, and drugs and a demonstration of talking to patients about sexual practices and concerns.

## Supplemental Examples and Potential Resources

The following pages contain:

- The basic communication skills training learning objectives, which are used for first-year medical students at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS), and information about how the lecture and skills training about sensitive topics fits within the overall context of the basic skills training program. The sensitive topic overall objectives are **highlighted in orange**.
- The “Patient History Format,” which is the detailed template used at the UNDSMHS to conduct a full medical history. This template reflects both the content and process of the UNDSMHS training in basic communication skills, including the sensitive topic areas addressed in this module. The sensitive topic screenings are **highlighted in orange**.
- Three of the cases designed for training the SPs used by students to practice a medical interview, which includes the sensitive topic areas. Our cases include only patients who engage in “risky” use, and patients who do not have diagnosable substance abuse problems. The sensitive topic areas for the cases are **highlighted in orange**. These topics could be modified to fit the particular needs and goals of a specific program. The goal of this module is to get students used to asking only the evidence-informed screening questions and using techniques to help broach these subjects. This module is not intended to address diagnosable substance abuse problems or how to handle a problem once it is identified; those skills are included at a more advanced level.

## Learning Objectives: Basic Communication Skills Training and Talking About Sensitive Topics

1. Learn and understand how good communication skills and a positive doctor-patient relationship improve patient outcomes and patient satisfaction.
2. Understand the difference, as well as the interaction, between content and process in performing a medical interview.
3. Learn the six major content domains of the medical history.
4. Be able to demonstrate knowledge of the six content domains of the medical history by performing medical interviews on SPs.
5. Learn the elements of process in gaining a medical history.
6. Be able to demonstrate knowledge of the elements of process during the performance of medical interviews on SPs.
7. Learn specific communication techniques that are critical to gaining an accurate medical history and developing a positive doctor-patient relationship.
8. Be able to demonstrate specific communication techniques that are critical to gaining an accurate medical history and developing a positive doctor-patient relationship by applying these techniques during medical interviews on SPs.
9. Learn to give feedback to peers pertaining to their interviewing performance on SPs.
10. Learn how to talk to patients about several sensitive topic areas that are a part of the medical history: drug/alcohol use history, IPV/domestic violence, and sexual history/concerns/topics.
11. Be able to demonstrate knowledge of the content areas and specific techniques for gathering sensitive information contained in the medical history through the performance of these skills on SPs.
12. Gain awareness and knowledge about cross-cultural communication and the medical encounter.
13. Understand the meaning of “health-care literacy,” the prevalence of problems with health-care literacy, and some tools for managing these issues in the medical encounter.
14. Clinical skills final exam: Be able to perform a complete medical history on an SP, demonstrating the six parts of the medical interview, the process elements involved in performing the history, and the critical communication techniques necessary for gaining accurate information and developing a positive rapport with patients.

**Patient History Format:  
Detailed Summary About How to Conduct the Interview**

**Introduction and Initiating the Session**

1. Introduce self: Give your first and last name and state that you are a first year medical student.
2. Greet patient using his/her full name and ask the patient how you should refer to him/her (e.g., Mr. Smith, Mike, Dr. Jones).
3. Attend to the patient's comfort (e.g., "Are you comfortable?" "Is there anything I can do to make you more comfortable?").
4. Verify chart information.

**Soliciting the Chief Complaint (CC) (Recorded in Patient's Own Words)**

1. Inquire about CC. Use an open-ended question to elicit the CC (e.g., "What brings you in today?" "What can I help you with today?").
2. Ask at least one more open-ended question to encourage the patient to fully explain the CC (e.g., "Can you tell me any more about [the problem(s)]?").
3. Listen attentively, without interrupting, until the patient has finished talking.
4. Use facilitative responses to encourage the patient to expand further about the problem.
5. Confirm the patient's problem list by summarizing what the patient has said (e.g., "So that's headaches and feeling tired all day?").
6. Screen one more time for any additional problems (e.g., "Is there **something** else?").
7. If patient states multiple problems, negotiate an agenda for gathering information and prioritizing problems (e.g., "Which one would you like to discuss?" "Which is of the greatest concern to you now?").

**[NOTE: Up to this point, the patient does almost all of the talking—you should not be asking any specific questions about the chief complaint; that occurs in the HPI.]**

**[Make a Transition to HPI: "Now I am going to ask you some more questions about (the problem)."]**

**History of Present Illness (HPI)—LOCATES MODEL**

Location of problem, if appropriate—where is the pain or injury?

If possible/appropriate, ask the patient to point to the location of the pain or injury.

Onset of problem:

Time of onset?

Was it an abrupt or a slow onset?

Character of problem—get a **DETAILED DESCRIPTION** of the problem:

Is your pain radiating, stabbing, aching, tingling, burning? Is your cough dry or loose?

What color is the sputum? What is the consistency and color of the stool?

Associated symptoms (e.g., "Are there any other symptoms that you are experiencing that seem to go along with [the problem]?" "That started around the same time as [the problem]?").

Aggravating factors (e.g., "What kinds of things, if any, make the problem(s) worse?").

Alleviating factors (e.g., "What kinds of things, if any, make the problem(s) better?" "What have you tried?").

Timing of problem(s) (e.g., "Is it constant pain?" "Is it worse or better at certain times of the day?" "Once it [the problem] started, has it progressively worsened? Does it come and go? Stay the same?").

Environment (i.e., setting when the problem onset) (e.g., “Were you doing anything specific when the problem onset, such as vacationing, lifting something, etc.?”).

Severity of problem (e.g., “On a scale of 1 to 10, with 10 being the worst and 1 being no problem at all, how severe is your cough? Stomach pain? Difficulty breathing?”).

Similar problems in the past (e.g., “Have you ever had anything like [the problem(s)] in the past?”).

**[Make a Transition:** “Now I am going to switch gears a little and ask you some questions about your personal views of the problem.”]

### **Elicit Patient’s Perspective of the Problem—This is Part of the HPI**

1. **Ideas and beliefs about the problem.** “I know you have come in today to try to find out what might be going on with your [state problem]; but what ideas, if any, have *you* had about what might be causing it?”
2. **Concerns and feelings about the problem.** “Sometimes people have concerns or worries about what might be causing a problem. What concerns, if any, do you have about your [state problem] or what it might be?”
3. **Expectations about the medical appointment.** “Sometimes people have some ideas about what should be done for a particular problem or about what should happen during their appointment. Do you have any specific ideas about what should happen during your appointment today? How about in terms of how we treat your [state problem]? Or in terms of what we might be able to do for your [state problem]?”
4. **Impact of the problem on the patient’s life.** “How has the [state problem] affected your life?” (e.g., ask about home, work, and social/family and life/activities.)

### **Transition to a SUMMARY of BOTH the HPI and the Patient’s Perspective of the Problem:**

You can transition to a summary by saying, “Let me see if I have this right,” or “I want to make sure I understand what you have just told me,” then proceed with a concise and detailed summary of the HPI and the patient’s perspective of the problem.]

Summarize **BOTH** the LOCATES information and the Patient’s Perspective information at this point in the interview—**ALWAYS**.

**ALWAYS** begin your summary by encouraging the patient to correct anything he/she hears that is inaccurate in your summary. Example: “Let me see if I have this right,” AND “Please stop me if you hear me say anything that is incorrect. You have had a stabbing pain in your lower abdomen for the last week. The pain started all of a sudden and has gotten worse since it began. [Continue with summary.] Is all that correct?”

In your summary, include both positive and negative findings. Example: “You have had pain in your lower abdomen (positive finding) and you can’t recall anything different that was going on when the problem started (negative finding). It is a good idea to summarize more often during the HPI if the presentation is more complex. For example, if the **CHARACTERIZATION** of the problem is quite involved, it is appropriate to summarize immediately after the patient has given that information as well as at the end.

**[Transition to PMH:** “Now I am going to change course a bit and ask you some questions about any other medical problems you currently have or have had in the past.”]

**Other Active Problems/Past Medical History (PMH)**

**Overall Health:** “How has your health been in general?” “How is your health in general?”

**Other Active Medical Problems:** “Do you have any other current/active medical problems?”

**Current Medications (Prescription):** “Do you currently take any prescription medication(s)?”

- M** Medication name.
- E** Effectiveness of the medication in treating a specified condition.
- D** Dosage: How much per administration and number of times taken each day?
- I** Indication: Why are they taking the medication?
- C** Clinician who prescribed the medication.
- A** Adverse effects/side effects.
- T** Timing: When did the patient start taking the medication?

**Current Medications (Non-prescription):** “Do you currently take any over-the-counter/non-prescription medication(s)?”

- Medication name.
- Indication—Why are they taking it?
- Dosage—How much per administration and number of times a day?
- Effectiveness in treating a specified condition.

**Current Medications (Supplements and Herbal Medications):** “Do you currently take any herbal or vitamin supplements?”

- Medication name.
- Indication—Why are they taking it?
- Dosage—How much per administration and number of times a day?
- Effectiveness in treating a specified condition.

**PMH:**

**Serious illnesses**

“Tell me about any serious illnesses you have had.”

- What? Describe the illness.
- When—when did the illness occur?
- Outcome—what was the outcome of treatment?

**Hospitalizations (for each one, ask about the following)**

“Have you ever been hospitalized?”

- When?
- Why?
- Where?
- Attending physician?
- Outcome—what was the outcome of the hospitalization?

**Surgeries (for each one, ask about the following)**

“Have you had any surgeries?”

- When?
- Why?
- Where?

- Attending physician?
- Outcome—what was the outcome of the surgery?

Serious injuries/trauma (for each one, ask about the following)

“What serious accidents or injuries have you had?”

- When?
- What happened?
- Outcome—what was the outcome of any treatment/recovery?

Reproductive history for women

As about number of pregnancies, live births, and birth complications.

Childhood illnesses

“How was your health when you were a child?” “Did you have any serious illnesses?”

Allergies

“Do you have any allergies?” If yes:

- “What is the allergy?”
- “What does the allergic reaction involve?”
- “What happens after exposure to the allergen?”

Immunizations (ask if they have had the immunization and, if so, when)

Ask about these **four**: tetanus, influenza, pneumonia, and hepatitis.

Health screening (be sure your questions are **age-** and **gender-appropriate**)

- Females: Ask about breast self-exam, mammogram, and regular gynecologic checkups (PAP and breast exam).
- Males: Prostate exam.
- Both males and females: Blood pressure, cholesterol, diabetes/glucose testing, and colonoscopy.

Personal safety

Ask about these **four**: seat belt usage, use of helmets, firearm storage, and sunscreen use.

[**Transition to FH**: “Now I am going to change course a bit again and ask you some questions about your family history.”]

**Family History (FH)**

**Parents:**

- Living or deceased? If deceased, age and cause.
- If living, age and any health problems?

**Siblings:**

- How many?
- How is their health?
- If any deceased, age and cause?

**Children:**

- How many?
- How is their health?
- If any deceased, age and cause?

**Grandparents:** (if appropriate to the patient's age)

- Living or deceased? If deceased, age and cause?
- If living, age and any health problems?

**Diseases Common in Family:** Ask about cancer, diabetes, stroke, heart attacks, kidney/liver disease, depression, and anxiety.

**Specific Familial Conditions Relating to Current Illness:** "Is there anyone in your family or who is living with you who has [state patient's CC]?"

**[Transition to Patient Profile or Social History:** "Now I would like to learn more about you as a person, so I am going to ask you some questions about yourself and your life."]

**Patient Profile (PP)/Social History (SH) Format****Demographics/Ethnicity:**

- "Where were you born/where did you grow up?"
- "What was your upbringing like?"
- "What is your ethnic background?"
- "Is there anything important I should know about your medical care as it relates to your ethnicity?"

**Occupation, Education:**

- "Are you currently employed?" [If yes] "What is your job?"
- [If appropriate] "Are there any physical/exposure risks?"
- "What is your stress level at work? Use scale of 1 to 10, with 10 being very stressful?"
- "How about your education; tell me a little about that."
- "Where did you go to high school?"
- "Have you ever attended college?"
- [Or if obvious from type of job] "Where did you attend college?"

**Nutrition/Diet:** "Regarding your diet, tell me what you eat in a typical day."

**Exercise:** "What do you do for exercise?"

**Tobacco:**

- "Have you ever used tobacco?"
- "How much tobacco do you use?" (Avoid asking the question in a yes/no format, such as "Do you smoke?")
- "How much have you used tobacco in the past?"
- "How many years?" "How much?" "Attempts to quit?"

***[Consider the need to prepare the patient to discuss sensitive topics.]***

**Alcohol:**

- “Have you ever used alcohol?”
- “How much in the last year?”
- “How many times per week?”
- “Typical amount?”
- “Greatest amount on any one occasion in the last month?”
- CAGE for dependency, two-item dependency screen

**Street Drugs:**

- Ask about each drug in same format as the questions for alcohol
- NMASSIST, ASSIST, or other screening tool can be utilized

**Prescription Drugs:**

- Ask about prescription drug misuse or abuse in the same format as the questions for street drugs and alcohol
- NMASSIST, ASSIST, or other screening tool can be utilized

**Hobbies/Leisure Activities:** “How do you like to spend your leisure time?” “Any hobbies?”

**Relationships/Support Systems/Domestic Violence:**

- “Tell me about your current family.” Or, “Who lives with you?”
- “Do you have any concerns about your relationships/marriage?”

***[Consider the need to prepare the patient to discuss sensitive topics.]***

**Intimate Partner/Domestic Violence:** “Have you ever felt afraid of your current partner? A past partner?”

**Upbringing:** “What was your upbringing like?”

**Support system(s):** “Who are your sources of social support?”

***[Consider the need to prepare the patient to discuss sensitive topics.]***

**Sexual Activity/Practices:**

- “Are you currently sexually active?”
- [If not] “When was your last sexual contact?”
- As appropriate, ask about:
  - Number of partners in last 2 months, last year, lifetime?
  - Frequency of contact?
  - Safe sex issues?
  - Contraception issues?
  - History of STD(s)? [Always ask unless the person has never had sexual contact.]
  - Age at first intercourse? [If female, always ask unless the person has never had sexual contact.]

**Sexual Concerns:** “Do you have any sexual concerns you would like to discuss today?”

**Spirituality:** “Any spiritual or religious concerns I should be aware of in terms of your medical care?”

**Standardized Patient Role: Sample Patient Case 1**  
**J.J. Wilkins**

The following is the typical order for this patient encounter.

Student should introduce himself/herself as a first-year medical student and offer to shake hands. He/she may ask how you wish to be addressed (Mr., first name).

**Identifying Information:**

Age:	Use your own.
Marital status:	Separated. Your wife kicked you out because of your drinking.
Employment:	Laid off now—usually work seasonal construction jobs.
Where do you live?	Grand Forks—moved here from Minneapolis in 1998.
Children?	None.
Primary physician?	Dr. Deere at Altru Family Medicine Residency.

**Chief Complaint:** (Why you came to see the doctor today.)

“My big toe hurts like hell.”

**History of Present Illness:** (Explanation of the chief complaint—LOCATES mnemonic.

Questions in parentheses below will likely be asked. Responses for the SP are provided.)

**LOCATION:** (Where is the pain?) Left toe. (Does the pain radiate [move around, do you feel it anywhere else?]) No.

**ONSET:** (When did this happen?) It came on suddenly 2 days ago.

**CHARACTER:** (Describe the pain—dull, sharp, throbbing, etc.) Sore; it feels like it’s on fire.

**AGGRAVATING FACTORS:** (Does anything make the pain WORSE?) Walking; wearing a tight shoe.

**ALLEVIATING FACTORS:** (Does anything give you relief from the pain?) Not walking; putting your foot up. You have taken ibuprofen for the last couple of days. It helps the pain somewhat, but does not make it go away entirely.

**ASSOCIATED SYMPTOMS:** (Are there any other symptoms you have been experiencing?) The toe is red and swollen. You think you might have a fever, but you haven’t taken your temperature. You don’t have any other type of symptoms.

**TIMING:** (How often do you have the pain and how long does it last?) Constant and getting worse.

**ENVIRONMENT:** (Is there anything that you can think of anything [new/different behavior, something you ate, etc.] that may have caused the pain?) No.

**SEVERITY:** (How bad [on a scale of 10] is the pain?) 7 or 8 on a scale of 10.

**SIMILAR PROBLEMS:** (Have you ever had anything like this before?) You were at the clinic 6 months ago because your feet were swollen; but it was nothing like this.

**Past Medical History:** The student will ask questions about previous hospitalizations, surgeries, accidents or injuries, allergies, current medications, or other active medical problems.

**Prescription Medications:** (MEDICATES mnemonic—asks for every prescription medication)

**Medication name:** HCTZ (hydrochlorothiazide).

**Effectiveness:** You don’t know, you did not go back for a follow-up appointment.

**Dosage:** 50 mg a day.

Indication: High blood pressure; you had gone to the doctor because your feet were swollen.

Clinician prescriber: Dr. Deere.

Adverse effects: None that you know of.

Time on medication: 6 months.

**Over-the-Counter Medications:** Just the recent ibuprofen.

**Herbal Medications:** None.

**Allergies:** (Medication or substance and reaction) Lorcet (pain medication); it caused hallucinations. It was prescribed during a hospital stay in 1990 for lower back strain.

**Hospitalizations:**

- **What?** Lower back strain.
- **Where?** Minneapolis.
- **When?** 1990.
- **Physician?** Don't remember.
- **Complications?** None really, but it took several months to get better.

**Surgery:**

- **What?** Stabbed during a mugging.
- **Where?** Minneapolis.
- **When?** 1998.
- **Physician?** Don't remember.
- **Complications?** You were in the hospital for about a week, but it healed fine.

**Trauma/Accidents:** The above mugging is also your traumatic event.

**Other active or ongoing medical problems or conditions?** Just the high blood pressure.

**Immunizations:**

- **Tetanus booster?** Three years ago, when you went to the ER for stitches when you cut your hand on the job.
- **Pneumovax?** No.
- **Flu?** No.
- **Hepatitis?** No.
- **Tuberculosis?** No.

**Health Maintenance:**

- **Cholesterol level?** Don't know that you've ever had it done.
- **Blood sugar?** Don't know.
- **Testicular and prostate exam?** No.
- **Colonoscopy?** No.
- **Eye exam?** Five years ago.
- **Dental exam?** Ten years ago.
- **Special diet?** None.
- **Exercise?** None.

**Family History:**

Family Member	Age if Living or at Death	Medical Problems/ Cause of Death
Mother	**Use your own history here	
Father	Died at age 58	Heart attack. Was an alcoholic.
Siblings	One brother, died at age 25	Car accident
Maternal GM	Don't know	
Maternal GF	Don't know	
Paternal GM	Don't know	
Paternal GF	Don't know	

**Social History:**<sup>+</sup>

Use your own history for the following if/when asked, unless answer is indicated.

**Habits:**

- **Tobacco:** Two packs a day since the age of 14.
- **Alcohol:** You admit to “going through” a fifth of vodka every couple of days for the past couple of years. **\*\*See more info below.**
- **Illicit drug use:** None.

**Upbringing:** Your father was an alcoholic who was physically and emotionally abusive when he was drunk. You left home at an early age.

**Education:** You never finished high school—11th grade.

**Marriages/Divorces:** Married 38 years.

**Relationship concerns:** Your wife kicked you out 3 months ago because of your drinking. The truth is you lost your construction job for not showing up at work on time.

**Sexual concerns:** If asked specifically, you don't have any interest in it right now.

**Spiritual concerns:** If asked specifically, you don't go to church and don't believe in God.

**Demeanor:** Basically cooperative, but you don't take very good care of your health and are drinking too much.

**\*\*After your response about drinking students may ask you the following questions:**

**CAGE** questions:

- Have you ever felt you ought to **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning (**E**ye-opener) to steady your nerves or to get rid of a hangover?

Your answers to the above:

**C**—Your wife has criticized you many times.

**A**—You get very annoyed with her, even very angry and abusive.

**G**—You don't feel guilty. You don't feel you have a problem. You've quit many times before and will again as soon as you get through this "rough patch."

**E**—You have a shot every morning to get you going—sometimes even a shot in the middle of the night when you can't sleep. You reluctantly admit to having blackouts "once in a while."

\*Highlight denotes items related to alcohol, tobacco, and other drugs.

(Remember when you are using your own history, you don't have to share anything you don't want to. However, don't make things up. "No," or "I don't know," or "I don't remember" can be acceptable answers. If you have any questions about the above info, let the facilitator know and he/she will clarify it for you.)

**\*\*\*Students may be asking some of the following questions about what you may be thinking or feeling about your current health problems. You should be able to answer these based on the details given in the case.**

How you FEEL about it? (i.e., How are you feeling about...? What are your worries about...? Do you think something serious is causing it?) **Your feeling and fears:**

How is it IMPACTING you? (i.e., How has it affected your daily life? Have you had to stop any activities?) **The impact on you:**

Your IDEAS about it? (i.e., What do think might be causing...? Do you think there is any relation between [your health problem] and what is going on in your life?) **Your idea is:**

What are your EXPECTATIONS about today's visit? (i.e., What do you think I can do to help you? Do you have any specific test or treatment in mind?) **Your expectation is:**

## Standardized Patient Role: Sample Patient Case 2 Rachel Barton

The following is the typical order for this patient encounter.

Student should introduce himself/herself as a first-year medical student and offer to shake hands. He/she may ask how you wish to be addressed (Ms., Miss, Mrs., first name).

### **Identifying Information:**

Age: Use your own.  
Marital status: Use your own.  
Employment: Use your own.  
Where do you live? Use your own.  
Children? Use your own.  
Primary physician? Dr. Eric Johnson, Altru Family Medicine (diabetes specialist)

### **Chief Complaint:** (Why you came to see the doctor today.)

"I've been throwing up all morning and I'm very tired now."

### **History of Present Illness:** (Explanation of the chief complaint—LOCATES mnemonic.

Questions in parentheses below will likely be asked. Responses for the SP are provided.)

**LOCATION:** (Where is the pain?) Although the vomiting is your main concern, you also report some cramping in your mid-abdomen. (Does the pain radiate [move around, do you feel it anywhere else]? No.

**ONSSET:** (When did this happen?) The vomiting began early this morning, but you started feeling ill yesterday (which is when you called to make today's appointment).

**CHARACTER:** (Describe the pain—dull, sharp, throbbing, etc.) Cramping.

**AGGRAVATING FACTORS:** (Does anything make the pain worse?) Nothing.

**ALLEVIATING FACTORS:** (Does anything give you relief from the pain?) Nothing.

**ASSOCIATED SYMPTOMS:** (Are there any other symptoms you have been experiencing?) You report some chills and fever. When the pain gets worse, you break out in a sweat and have more nausea. You also report a sore throat, fatigue, and having had insomnia over the last 2 weeks. You do not have diarrhea, constipation, or any urinary complaints. There is no blood in the vomit.

**TIMING:** (How often do you have the pain and how long does it last?) Since yesterday afternoon; it comes and goes with varying intensity.

**ENVIRONMENT:** (Is there anything that you can think of anything [new/different behavior, something you ate, etc.] that may have caused the pain?) Not really. You went out to dinner with family and friends the night before last and the shrimp you ordered didn't taste very good. However, no one else in the group is sick.

**SEVERITY:** (How bad [on a scale of 10] is the pain?) It varies from a 2 to a 7.

**SIMILAR PROBLEMS:** (Have you ever had anything like this before?) "I guess, maybe, when I've had the flu."

**Past Medical History:** The student will ask questions about previous hospitalizations, surgeries, accidents or injuries, allergies, current medications, or other active medical problems.

**Prescription Medications:** (MEDICATES mnemonic—asks for every prescription medication)

**M**edication Name: Humalin 70/30.

**E**ffectiveness: Yes.

**D**osage: 60 units, three times a day before meals.

**I**ndication: Type II diabetes.

**C**linician Prescriber: Dr. Johnson.

**A**dverse Effects: None.

**T**ime on Medication: 3 or 4 years.

**M**edication Name: Glucophage XR (Metformin).

**E**ffectiveness: Yes.

**D**osage: 1500 mg (three 500 mg tablets) before bedtime.

**I**ndication: Type II diabetes.

**C**linician Prescriber: Dr. Johnson.

**A**dverse Effects: None.

**T**ime on Medication: 3 or 4 years.

**Over-the-Counter Medications:** Just Tylenol or Advil for aches and pains.

**Herbal Medications:** Flaxseed oil for high cholesterol; three 1,000 mg capsules per day.

**Allergies:** (Medication or substance and reaction)

None that you know of.

**NOTE:** For the following items, you may use your own history if you would like. Talk about only one hospitalization, one surgery, and one trauma/accident. If you say you have children as part of your history, don't forget to mention their birth(s) when the student asks about hospitalizations. Say the births were normal with no complications.

If the student asks about menstrual history, it's probably easiest to base it on your own history.

**Hospitalizations:** What? Where? When? Physician? Complications?

**Surgery:** (Use your own; if none, just say none.)

What? Where? When? Physician? Complications?

**Trauma/Accidents:** (Use your own; if none, just say none.)

What? How did it happen? Where? When? Complications?

**Other Active or Ongoing Medical Problems or Conditions:** No, just the diabetes.

**NOTE:** For the following items, use your own history here unless indicated otherwise.

**Immunizations:**

- Tetanus booster?
- Pneumovax?
- Flu?
- Hepatitis?
- Tuberculosis?

**Health Maintenance:**

- **Cholesterol level?** A little on the high side but not high enough to be on medication for it; the flaxseed oil seems to be helping.
- **Blood sugar?** Normally 100 in the morning and 140 after meals; the last couple of days, due to stress, it has been 250 to 275. Your last A1C level 6 months ago was 6.5.
- **Pap smear?**
- **Mammogram?**
- **Eye exam?**
- **Dental exam?**

**Stress:** Your father’s recent death is the stress that has caused your blood sugar jump and your other symptoms. Your aunt is upset and blaming the family for the death of her brother (your father). Even though it has been a few weeks since his death, she still can’t let it go. The family (you, your mother, and your brother) decided against any heroic measures after being told your father would not come out of his coma.

**Family History:**

Family Member	Age if Living or at Death	Medical Problems/ Cause of Death
Mother	Age 73 (or appropriate age based on Rachel’s age)	Good health
Father	Died 3 weeks ago, age 75 (or appropriate age based on Rachel’s age)	Stroke
Siblings	One older brother	Has diabetes
Maternal GM	**Use your own history here	
Maternal GF	**Use your own history here	Had diabetes
Paternal GM	**Use your own history here	
Paternal GF	**Use your own history here	

**Social History:** +

Use your own history for the following if/when asked, unless answer is indicated.

**Nutrition and diet:** Try to follow a diabetic diet.

**Exercise:** Use your own.

**Habits:**

- **Tobacco:** Never.
- **Alcohol:** Drink “socially” (despite negative effect on health); always liked to have a few glasses of wine to relax with dinner. Don’t offer this unless asked→ most often 2 to 3 glasses, 3 to 5 times a week. Have done this for years. Don’t offer unless asked→ Never a time when you had more than 4 to 5 drinks on any occasion.
- **Illicit drug use:** None, ever.
- **Prescription drug abuse/misuse:** One time, recently, took husband’s anxiety medication because of stress (clonazepam).

The following, if asked, should be answered positively and affirmatively (e.g., you have good support, no sexual concerns, no spiritual concerns, etc.).

- **Upbringing:**
- **Education:**
- **Marriages/Divorces:**
- **Relationship concerns:** With aunt over father's death.
- **Sexual activity:** Sexually active with long-term partner; one partner in lifetime.
- **Sexual concerns:** None
- **Spiritual concerns:** None.

**Demeanor:** Cooperative, but you are tired and don't really feel well.

+ Highlight denotes items related to alcohol, tobacco, and other drugs.

(Remember when you are using your own history, you don't have to share anything you don't want to. However, don't make things up. "No," or "I don't know," or "I don't remember" can be acceptable answers. If you have any questions about the above info, let the facilitator know and he/she will clarify it for you.)

**\*\*\*Students may ask some of the following questions about what you may be thinking or feeling about your current health problems. You should be able to answer these based on the details given in the case.**

How you **FEEL** about it? (i.e., How are you feeling about...? What are your worries about...? Do you think something serious is causing it?) **Your feeling and fears:** Your diabetes may be getting worse.

How is it **IMPACTING** you? (i.e., How has it affected your daily life? Have you had to stop any activities?) **The impact on you:**

Your **IDEAS** about it? (i.e., What do think might be causing it...? Do you think there is any relation between [your health problem] and what is going on in your life?) **Your idea is:** Stress might be causing problem.

What are your **EXPECTATIONS** about today's visit? (i.e., What do you think I can do to help you? Do you have any specific test or treatment in mind?) **Your expectation is:**

**Standardized Patient Role: Sample Patient Case 3  
Andrea Sands**

The following is the typical order for this patient encounter.

Student should introduce himself/herself as a first-year medical student and offer to shake hands. He/she may ask how you wish to be addressed (Ms., Miss, Mrs., first name).

**Identifying Information:**

Age:	Use your own
Marital status:	Use your own
Employment:	Use your own
Where do you live?	Use your own
Children?	Use your own
Primary physician?	Use your own

**Chief Complaint:** (Why you came to see the doctor today.)  
Feel tired and weak all the time.

**History of Present Illness:** (Explanation of the chief complaint—LOCATES mnemonic.  
Questions in parentheses below will likely be asked. Responses for the SP are provided.)

**LOCATION:** (Where is the pain?) Low back. (Does the pain radiate [move around, do you feel it anywhere else]?) Some radiation.

**ONSET:** (When did this happen?) About 6 months ago; started feeling tired.

**CHARACTER:** (Describe the pain—dull, sharp, throbbing, etc.) Back pain is an aching pain of moderate severity. You are tired with no energy; it's hard to get things done around the house. You want to nap or sleep several times during the day. You do not think this is just due to depression because it started before the depression, although the depression has made it worse.

**AGGRAVATING FACTORS:** (Does anything make the pain WORSE?) Nothing.

**ALLEVIATING FACTORS:** (Does anything give you relief from the pain?) Zoloft has helped with depression; take Tylenol sometimes for lower back pain, and it helps some but not completely.

**ASSOCIATED SYMPTOMS:** (Are there any other symptoms you have been experiencing?) Starting about the same time as your tiredness, you lost interest in sex. Over the past 3 months you have been depressed, and that has gotten worse; have gotten treatment for that (taken Zoloft for past 2 months). Your menstrual periods have been irregular for the last 3 months. You notice that you bruise more easily. You have gained 15 pounds over the last 6 months. Also, for the last month, you have noticed more hair growth on your upper lip.

**TIMING:** (How often do you have the pain and how long does it last?) Feel tired almost all the time; no part of the day is better than others.

**ENVIRONMENT:** (Is there anything that you can think of anything [new/different behavior, something you ate, etc.] that may have caused the pain?) No.

**SEVERITY:** (How bad [on a scale of 10] is the pain?) 4 or 5 on a scale of 10.

**SIMILAR PROBLEMS:** (Have you ever had anything like this before?) No.

**Past Medical History:** The student will ask questions about previous hospitalizations, surgeries, accidents or injuries, allergies, current medications, or other active medical problems.

**Prescription Medications:** (MEDICATES mnemonic—asks for every prescription medication)

**M**edication Name: Zoloft.

**E**ffectiveness: Your mood is better. Feel a little more interested in your normal hobbies, but are just too tired to do many of them.

**D**osage: 100 mg, one time a day (bedtime).

**I**ndication: Depression.

**C**linician Prescriber: Dr. Moore.

**A**dverse Effects: Some gastrointestinal upset for the first week, but nothing since.

**T**ime on Medication: 2 months.

**Over-the-Counter Medications:** Tylenol; take once or twice a day sometimes for back pain as directed on bottle.

**Herbal Medications:** Vitamins.

**Allergies:** Bacterim (antibiotic); huge hives all over your body.

**Hospitalization:** (If you say you have children as part of your history, don't forget to mention their birth(s) when the student asks about hospitalizations. Say the births were normal with no complications.)

- **What problem?** Hospitalized for tonsillectomy as a child.
- **Where hospitalized?** Altru Family Medicine.
- **When hospitalized?**
- **Who (physician)?** Dr. Moore.
- **Complications?** None.

**Surgery:** (Use your own history here; but only talk about one of your surgeries if you have had multiple ones. If you have had no surgeries, say none.)

- **What type of surgery?**
- **Where performed?**
- **When performed?**
- **Who (physician)?**
- **Complications?**

**Trauma:** (Use your own history here; but only talk about one trauma/accident if you have had multiple ones. If you have had no traumas/accidents, say none.)

- **What type of injury?**
- **How sustained?**
- **Where hospitalized?**
- **When hospitalized?**
- **Complications?**

**Other Active Medical Problems:** None.

**Immunizations:** (Use your own history here.)

- **Influenza?**
- **Pneumonia?**
- **Tetanus?**
- **Hepatitis?**
- **Tuberculosis?**

**Health Maintenance:** (Use your own history here.)

- **Cholesterol level?**
- **Blood sugar?**
- **Pap smear?**
- **Mammogram?**
- **Eye exam?**
- **Dental exam?**
- **Special diet?** No special diet, but you seem to be gaining weight—your clothes are getting tight—maybe 15 lbs over the last 6 months.
- **Exercise?** Usually very active and involved in regular aerobic exercise and swimming; you have been too tired and fatigued lately to do this.

**Family History:**

Family Member	Age if Living or at Death	Medical Problems/ Cause of Death
Mother	**Use your own history here	Depression; diabetes
Father	**Use your own history here	Stroke
Siblings	Older bother killed in car accident 2 years ago	
Maternal GM	**Use your own history here	
Maternal GF	**Use your own history here	
Paternal GM	**Use your own history here	
Paternal GF	**Use your own history here	

**Social History:**<sup>+</sup>

**Habits:**

- **Tobacco:** Not currently; used to smoke 1 pack a day from ages 21—\_\_.
- **Alcohol:** Drink occasionally, 1 or 2 drinks, usually wine with dinner, maybe 2 times per month. Most ever drank was in college, got “pretty drunk” a couple of times and had 5 or 6 drinks. Haven’t done that for years; hate hangovers.
- **Illicit drugs:** Smoked marijuana “a few times”; tried cocaine one time (“snorted”) at a party; never used meth or any other drug.
- **Prescription drug use/misuse:** Never abused prescription drugs.

The following, if asked, should be answered in a positive and affirmative manner (i.e., you have good support, good upbringing, no spiritual concerns, etc.).

- **Upbringing:**
- **Education:**
- **Marriages/Divorces:**
- **Relationship concerns:**
- **Sexual concerns:** Right now, you have no interest in sex; this lack of interest started about the same time as your tiredness, but it has gotten worse over the last 6 to 8 weeks. You are unable to reach orgasm if you do engage in sexual activity. It is causing some problems in your relationship. Had a very good sexual relationship previously—had no concerns. Lifetime # partners is \_\_. No history of sexually transmitted diseases. Age of first intercourse \_\_.
- **Spiritual concerns:** None.

<sup>+</sup> Highlight denotes items related to alcohol, tobacco, and other drugs.

**Demeanor:**

Cooperative. You appear to be tired, low energy, and somewhat depressed.

(Remember when you are using your own history, you don't have to share anything you don't want to. However, don't make things up. "No," or "I don't know," or "I don't remember" can be acceptable answers. If you have any questions about the above info, let the facilitator know and he/she will clarify it for you.)

**\*\*\*Students may be asking some of the following questions about what you may be thinking or feeling about your current health problems. You should be able to answer these based on the details given in the case.**

How you FEEL about it? (i.e., How are you feeling about...? What are your worries about...? Do you think something serious is causing it?) **Your feeling and fears:** You worry that it might be diabetes because your mother has/had diabetes.

How is it IMPACTING you? (i.e., How has it affected your daily life? Have you had to stop any activities?) **The impact on you:** Impacting you a great deal because you are so tired.

Your IDEAS about it? (i.e., What do think might be causing...? Do you think there is any relation between [your health problem] and what is going on in your life?) **Your idea is:** Premature menopause; diabetes.

What are your EXPECTATIONS about today's visit? (i.e., What do you think I can do to help you? Do you have any specific test or treatment in mind?) **Your expectation is:** Want blood tests to see if you are developing diabetes.