PBL Case #4: Misplaced Memories

Your Role:
You are a group of family medicine physicians at an urban hospital, with a patient case load of middle aged and senior citizens. You're paged to the ER when a patient of yours, who you saw a few weeks ago, is brought in by his wife.

Background:
Roger Stevens, a retired economics professor, has been married to his wife for 46 years. His medical records show that he has been treated for hypertension and diabetes in the past. Recently, his wife has expressed concern that he's becoming more forgetful.

Objectives:

Determine whether Professor Stevens has any neurological or other conditions and recommend a course of treatment that will keep him as healthy as possible.

Assessment:

-SOAP notes
-1-2 min. presentation of diagnosis to Dr. Stevens and his wife.

Possible Resources:

--PBL Toolbox "Finding Info" section at uiccphealthscience.weebly.com
--eTextbook "Nervous System" pgs 226-278

<table>
<tr><th colspan="2">Subjective</th><th>Objective</th></tr>
<tr><td>SAMPLE history
Signs & Symptoms
Allergies
Medications
Past History (Social, Family)
Last oral intake
Events leading to injury/illness</td><td>Symptom Assessment (often for pain)
Frequency
Associated symptoms
Radiation
Character
Location
Duration
Exacerbating factors
Relieving factors</td><td>• Measurements (ex: age and weight)
• Vital signs (ex: heart rate, blood pressure, respiratory rate, temperature)
• Physical exam results (ex: bruising)
• Results from labs (ex: X-ray, MRI, blood analysis)</td></tr>
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<u>A</u>ssessment	<u>P</u>lan
• Quick summary of the patient including main symptoms • Differential diagnosis, (a list of possible diagnoses in order of most likely to least likely) • Final Diagnosis	• Step-by-step plan for treatment and follow-up (patient instructions, procedures performed, medications given) • Additional tests to run (ordering labs, radiological work up, referrals)

SOAP Notes

Subjective: This describes the patient's current condition in narrative form. The history or state of experienced symptoms are recorded, concisely, in the patient's own words. If the patient is unconscious or cannot speak for himself/herself, often family members, caregivers, witnesses at the scene, or others can provide information.	
Signs & **S**ymptoms*	
Allergies	
Medications	
Past medical history **Social:** *alochol, smoke, drug use, marital status, children, occupation, sexual history, living situation, etc.* **Family:** *conditions & diseases run in the family*	
Last oral intake	
Events leading to injury or illness	
***F**requency	
***A**ssociated Symptoms	
*__R__adiation	
*__C__haracter	
***O**nset	
*__L__ocation	
***D**uration	
***E**xacerbating Factors	
***R**elieving Factors	

Objective: Empirical (data-driven) record of patient's condition (quantitative information)	
Measurements (ex: age, weight)	
Vital Signs (BP, HR, RR, Temp)	
Physical Exam Results	
Lab Results	

Assessment: Quick summary of the patient with main symptoms/diagnosis including a differential diagnosis, a list of other possible diagnoses usually in order of most likely to least likely.	
Summary Diagnosis Differential Diagnosis List	

Plan: This is what the health care provider will do to treat the patient's concerns - such as ordering labs, radiological work up, referrals given, procedures performed, medications given. This should address each item of the differential diagnosis. A note of what was discussed or advised with the patient as well as timings for further review or follow-up may also be included.	
Plan steps	