Medical Student Case Report Template

Title:
A short, clear description of the case.

History

1) Presenting Complaint:
>State the reason the patient sought medical attention.
>Patient age, sex and hand dominance
>Main symptom and duration of main symptom

2) History of Presenting Complaint
>When did the symptoms start?
>How did they develop or progress?
>What makes the symptoms worse?
>What relieves the symptoms?
>Are there associated symptoms?
>Has the patient had any previous treatment or investigations?

3) Past Medical History
>List relevant previous illnesses, operations, or injuries, with dates for each

4) Drug History
>Current medications
>Drug allergies

5) Systematic Enquiry
>Relevant symptoms from other systems. Include only positive findings:
>*General:* Weight loss; Fever; Night sweats; Fatigue
>*Cardiovascular:* Chest pain; Palpitations; Shortness of breath on exertion; Ankle swelling
>*Respiratory:* Cough; Shortness of breath; Wheeze; Haemoptysis
>*Gastrointestinal:* Abdominal pain; Change in bowel habit; Nausea or vomiting; Loss of appetite
>*Neurological:* Weakness; Sensory change; Paraesthesia; Coordination problems
>*Musculoskeletal:* Joint pain/ stiffness/ swelling
>*Endocrine / Metabolic:* Symptoms of diabetes; Heat or cold intolerance; Weight change

6) Family History
>Relevant medical conditions in close relatives.
>Children

7) Social History
>Occupation, living arrangements (who is at home). Smoking and alcohol intake
>Relevant activities and hobbies

Examination findings

General Presentation
Overall appearance of the patient.
Local Examination
Inspection; Swelling; Deformity; Scars; Skin changes; Palpation; Tenderness; Masses
Movement
Active range of motion; Passive range of motion
Function, Strength, Dexterity
Systemic Examination
Pulse, blood pressure, temperature. Chest examination and heart sounds.
Abdominal examination

Special Tests
Condition specific tests

Investigations
Radiology; Blood tests; Nerve conduction studies

Diagnosis

Management

Key Learning Points

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