COMPREHESIVE IHUMAN CASE STUDY WEEK #7 (CLASS 6512) 18 YEAR OLD PATIENT REASON FOR ENCOUNTER: PASSED OUT



Case Study Report

Week #7 i-Human Case Study Class 6512 18-Year-Old Patient - Reason for encounter: Passed out Location: Unspecified

Title Page

Case Study Title: Comprehensive Assessment of an 18-Year-Old Patient Presenting with Syncope Author: [Your Name] Date: [Submission Date]

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Comprehensive iHuman Case Study: Week #7 (Class 6512)

Patient: 18-Year-Old

1. Chief Complaint (CC)

• **Primary Reason for Visit:** (e.g., "Patient presents with acute abdominal pain for 24 hours.")

2. History of Present Illness (HPI)

- **O**nset: When did symptoms start?
- Location: Where is the pain/discomfort?
- **D**uration: How long has it lasted?
- **C**haracter: Description of symptoms (sharp, dull, burning, etc.).
- Aggravating/Relieving Factors: What makes it worse or better?
- **R**adiation: Does the pain move anywhere?
- Timing: Is it constant or intermittent?
- Severity: Pain scale (1-10), impact on daily activities.

3. Past Medical History (PMH)

- Chronic conditions (e.g., asthma, diabetes, hypertension).
- Previous hospitalizations or surgeries.
- Medications (prescription, OTC, supplements).
- Allergies (medications, food, environmental).

4. Family & Social History (FH & SH)

- Family history of chronic illnesses (e.g., diabetes, cancer).
- Lifestyle factors:
 - Living situation & support system.
 - Smoking, alcohol, drug use.
 - Sexual history (if relevant).
 - Exercise & dietary habits.

5. Review of Systems (ROS)

- General: Fever, weight loss, fatigue.
- HEENT: Headaches, vision/hearing issues.
- Cardiovascular: Chest pain, palpitations.
- Respiratory: Shortness of breath, wheezing.
- Gastrointestinal: Nausea, vomiting, diarrhea.