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

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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?
- **L**ocation: Where is the pain/discomfort?
- **D**uration: How long has it lasted?
- **C**haracter: Description of symptoms (sharp, dull, burning, etc.).
- **A**ggravating/Relieving Factors: What makes it worse or better?
- **R**adiation: Does the pain move anywhere?
- **T**iming: Is it constant or intermittent?
- **S**everity: 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.