PATIENT CHART

Mike Walker Simulation #1

SBAR Report Students Will Receive Before Simulation

**Time:** 1100

**Person providing report:** Urgent Care Receptionist

**Situation:** Mike Walker is a 70-year-old man being seen for rectal bleeding.

**Background:** Mike has not been seen here before and does not have a primary care physician.

**Assessment:** None available at this time.

**Recommendation:** Please complete vital signs, review history intake form and complete a focused gastrointestinal and sexual assessment on an adult in the emergent care center. Provide an SBAR report to the attending Nurse Practitioner.

**Urgent Care Intake Form: General Medical Questionnaire**

**Instructions:** Patient please complete this form prior to seeing the healthcare providers.

**Patient Name:** Mike Walker **Date of Birth:** 10/15/YYYY(reflect age 70)

Have you EVER had any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma/Breathing ProblemsArthritisBleeding/Clotting DisorderBlood Pressure DisorderBlood TransfusionBowel/Stomach ProblemsCancerCholesterol DisorderDiabetesEye Disorder (e.g. glaucoma, cataract)Heart Disease/Disorder | [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [x]  Y [ ]  N [ ]  Y [x]  N [x]  Y [ ]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N  | Lung DisorderLiver DiseaseNeurological Disorder/Chronic HeadachesPsychiatric Disorder/IllnessPulmonary Embolism/DVTStrokeSeizure or EpilepsyThyroid DisorderUrinary/Kidney DisorderIf Relevant: Gynecological Issues | [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [x]  N [ ]  Y [ ]  N [x]  N/A  |

**Please list any other medical illnesses or problems and provide details for any of the above conditions**:

High Blood pressure, heartburn

**Please list all past surgeries and hospitalizations and the approximate date.**

|  |  |  |
| --- | --- | --- |
| **Procedure/ Hospitalization**  | **Date**  | **Complications** |
| TonsillectomyRepair of fractured ankle | Age 14Age 60 | NoneNone |

**Please indicate any major conditions/illnesses that your immediate family members have had:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relative**  | **Condition and description**  | **Living?**  | **If deceased, at what age?**  |
| Mother  | Colon Cancer | No | 72 |
| Father  | Stroke | No | 85 |
| Sibling  | None |  |  |
| Other:  |  |  |  |

**Social History**

Do you currently smoke? [ ]  Y [x]  N If no, previously? [ ]  Y [x]  N

Years smoked \_\_\_\_\_\_ Packs/day \_\_\_\_\_ Do you use other tobacco products? [ ]  Y [x]  N

Consume alcohol? [x]  Y [ ]  N If yes, drinks/ week: 5-6 drinks per week

**Reproductive/ Sexual Health**

Are you sexually active? [x]  Y [ ]  N

Do you consider yourself to be? [ ]  Heterosexual or straight [x]  Gay or lesbian [ ]  Bisexual

[ ]  Not listed, please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What sex were you assigned at birth? [x]  Male [ ]  Female

Current gender identity? [x]  Male [ ]  Female [ ]  Transgender Male/Trans man

[ ]  Transgender Female/ Trans woman [ ]  Genderqueer/non-binary

[ ]  Other, please state: \_\_\_\_\_\_\_\_\_

In the past year, have you had sex with? [x]  Men only [ ]  Women only [ ]  Both men and women

[ ]  Not listed, please state: \_\_\_\_\_\_\_\_\_\_\_ [ ]  I have not had sex

What type of sexual contact have you had? [ ]  Genital sex (penis in vagina) [x]  Oral sex (mouth on penis)

[ ]  Anal sex (penis in the anus) [ ]  Other (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any sexually transmitted diseases? [ ]  Y [x]  N

If relevant: Date of your last menstruation or age of menopause \_\_\_\_N/A\_\_\_

Last Pap Smear \_\_ N/A\_\_\_\_\_\_ Last mammography \_\_\_N/A \_\_\_\_\_\_

If relevant: Any past pregnancies? [ ]  Y [ ]  N How many? \_\_\_ How many deliveries? \_\_\_\_

Do you have any discharge from or lumps in your breast or chest? [ ]  Y [ ]  N [x]  N/A

If relevant: Do you have sores or lumps on your penis or testicles? [ ]  Y [x]  N [ ]  N/A

**Functional Assessment**

Do you use any equipment (such as a walker or wheelchair) to assist in your daily life?

[ ]  Y [x]  N If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_

Do you have difficulty performing daily tasks such as bathing, dressing or cooking? [ ]  Y [x]  N

Have you fallen in the past 6 months? [ ]  Y [x]  N

Do you have difficulty with balance or walking? [ ]  Y [x]  N

Do you have any allergies to medications or other substances (pets, food, etc.)? [ ]  Y [x]  N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Please list ALL your current medications, including over the counter medications, supplements, and herbs:

|  |  |
| --- | --- |
| **Medication Name** | **Dose** |
| Famotidine (Pepcid) | 10 mg every day |

**Review of Systems** Please indicate ALL that you have experienced within the past 6 – 12 months. Mark Y for Yes, otherwise leave blank.

**Constitutional**

* Fever
* Chills
* Fatigue
* Feeling poorly Y
* Sweats
* Weight gain
* Weight Loss Y
* Trouble sleeping

**HEEENT**

* Vision problem
* Double vision
* Eye Pain
* Itching/red eyes
* Runny nose
* Neck stiffness
* Nosebleed
* Congestion
* Smoking
* Dry mouth
* Flu like symptoms
* Sore throat
* Hoarseness
* Ringing in ears
* Vertigo
* Earache
* Hearing loss
* Other

**Cardiovascular**

* Chest pain
* Palpitations
* Leg swelling
* Cold hands or feet
* Leg pain w/ walking
* Irregular heartbeat/rhythm

**Respiratory**:

* Shortness of Breath
* Cough
* Rapid breathing
* Wheezing
* Chest congestion
* Coughing up blood
* Coughing up mucous
* Other

**Gastrointestinal**:

* Abdominal pain
* Blood in stool Y
* Vomiting
* Nausea
* Constipation
* Diarrhea
* Black/tarry stools Y
* Decreased appetite
* Yellow skin
* Trouble swallowing
* Change in bowel habits
* Vomiting blood
* Bowel Incontinence
* Rectal Pain *Sometimes*
* Heartburn
* Painful swallowing
* Other

**Neurological**

* Headache
* Dizziness
* Decreased strength
* Poor coordination
* Unsteady
* Disorientation
* Confusion
* Burning sensation
* Numbness
* Tingling
* Seizures
* Fainting
* Tremor
* Memory Lapse/Loss

**Musculoskeletal**

* Joint Pain
* Neck Pain
* Back Pain
* Limb Pain
* Joint swelling
* Muscle cramps
* Muscle pain
* Muscle weakness
* Leg swelling
* Other

**Genitourinary**

* Frequent urination
* Incontinence
* Urinary urgency
* Painful urination
* Pelvic Pain
* Urinating during the night
* Itching- genital
* Change in Libido
* Painful intercourse
* Discharge-vaginal
* Vaginal bleeding
* Irregular monthly cycles
* Heavy period bleeding
* Other

**Integumentary**

* Rash
* Dry Skin
* Skin wound
* Change in a mole
* Unusual growth
* Itching
* Skin cancer
* Other

**Psychiatric**

* Depression
* Anxiety
* Other

**Hematologic/Lymphatic**

* Easy bruising
* Easy bleeding
* Swollen Lymph Nodes
* Other

**Endocrine**

* Excessive thirst
* Cold/heat intolerance
* Changes in hair
* Changes in skin
* Other

Provider Orders

**Allergies/Sensitivities: None Known**

|  |  |
| --- | --- |
| **Date/Time:** |  |
|  |  |
|  |  |

Progress Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
|  |  |
|  |  |
|  |  |

Nursing Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
|  |  |
|  |  |