Outline for Standardized Patient Script

**Opening Statement:** what is the first thing the patient will say to the student?

**History Content:** be as detailed as possible. For example, under medications, describe the dose, how long the patient has been taking it, and who prescribed it. By the time the SP is finished reading the history, they should have a good idea of who the patient is and how they should react.

**History of Present Illness:** describe in detail location, quality, quantity, onset, duration, frequency, aggravating/alleviating factors, associated symptoms.

**Past Medical History:** describe prior illness/hospitalization, allergies, immunizations, medications. Some case authors instruct SPs to use their own past history as long as the facts don't affect the case.

**Family History:** include ages, gender, and health status of all members.

**Social History:** describe age, marital status, lifestyle, hobbies, habits, including alcohol, tobacco, and illicit drugs, home situation, occupation, religion/spiritual history, sexual history.

**Review of Systems:** describe any pertinent findings.

**Physical Exam results:** describe any pertinent findings. For simulated symptoms, be very detailed using language the SP will understand. In training the SP, the clinician should demonstrate how findings should look and how the SP should act.

**Case Objectives**
STUDENT INSTRUCTIONS
STANDARDIZED PATIENT SCRIPT

Case Summary

Why you are seeing the doctor

What you think is causing the illness

What you fear most about the illness

What you want from the doctor (treatment, tests)

History of your illness

What problems have been caused by your illness

Overall Health

Current Physician
General Review of Systems

Past Medical History-

Allergies

Medication/Over the Counter medicine/Herbal or other Preparations

Social History

Health Insurance

Family History

How you look during the encounter

Concerns you have/questions for the doctor