CASE PRESENTATION FORMAT

Patient Identification
Chief complaint (CC)
History of the present illness (chronology of events) (HPI)
Past medical hx/Past surgical hx (PMH/PSH)
Meds
Allergies
Family history (FH)
Drug history/substance use
Social history (SH)
OB-GYN history
Sexual history
Review of systems (ROS)
Physical exam (PE)
Laboratory and diagnostic imaging results
Summary of the case
Assessment/differential diagnoses
Plan