CASE PRESENTATION FORMAT

Patient Identification; mention that history obtained from patient, patient's family member(s), available records (e.g. patient unable to speak); *optional piece depending on nature of the presentation

Chief complaint (CC)
History of the present illness (chronology of events) (HPI)
Past medical hx/Past surgical hx (PMH/PSH)
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 based on the information presented and what is the most likely diagnosis

Plan for management of the patient—what's next?