Nr 602 I human Chamberlain

Maddison Patton

24 y/o
5' 5" (165 cm)
125.0 lb (56.8 kg)

Reason for encounter
Referred for mood

Location
Outpatient clinic with laboratory capabilities

Rate Page

Case Instructions

BASIC DDx CASE PLAY SETUP AND INSTRUCTIONS

MODE:

This assignment is in Test Mode, so you will not be provided with any feedback after submitting each section.

ATTEMPTS AVAILABLE:

- You are permitted 1 attempt for this assignment.

GRADING RUBRIC:

- History 40%
- Physical exam 30%
- Differential diagnosis 10%
- Differential diagnosis ranking 10%
- Tests 10%

- Any sections not specified in the grading rubric do not count towards the Total Case Play Score.

HISTORY:

- To ask questions, you may type into the search box and select your desired question, or you may use the pre-populated question bank in the middle of the screen to search by category and select your desired question.
- Notate your Key Findings in the "Key Findings" section, and document your History in the EHR.

HISTORY QUESTION LIMIT:

Case authored by: i-Human Content Team

Visit: 14 days ago

History | Physical Exam | Assessment / Plan | Results

collapse all

History of Present Illness

Reason for Encounter:

Fatigue

History of Present Illness:

The patient is an otherwise healthy 24-year-old female who presents following a 8-day episode of sleeplessness and "super happy" mood. She went shopping and maxed out her credit, couldn't afford gas to get home. Called family for help. Reports a night out on the town where she drank much more than usual and needed help from a friend to get home. Subsequently awoke after 2-3 hours of sleep and started building a business plan for a company that would "save the souls of each and every person it served". She was calling investors, important people she knew who could help get the business started and called a family friend. The friend noted pressured and fast speech and strange ideas, called the patient's mother. Stepmom went to the patient's house to stay with her until the patient's mood and energy began to de-escalate, occurring later that evening and ending with about 10 hours of solid sleep. Elated mood has not returned since, nor has insomnia. She presents here at the insistence of her stepmother since they will soon be going out of town and want to ensure her safety before leaving. She denies suicidal plan or homicidal thoughts. She has not tried any medications or seen other providers for these symptoms, denies having them before. She endorses somewhat depressed and irritable mood today but denies rashes, chills, temperature intolerance, polydipsia, polyuria, headaches, lightheadedness, syncope, chest pain, shortness of breath, palpitations, coughing, wheezing, nausea, abdominal pain, vaginal discharge, weakness, numbness, substance use, hallucinations, paranoid ideations, bizarre delusions, or anxiousness.

Review of Systems

General:

Denies fever, weight loss, or weight gain

HEENT / Neck:

Denies change in facies or blurry or double vision outside of usual

Cardiovascular:

Denies chest pain or palpitations

Respiratory:

Denies coughing, shortness of breath, or wheezing

Gastrointestinal:

Denies nausea, vomiting, diarrhea, or abdominal pain

Genitourinary:

Denies discharge, lesions, or itching. Denies dysuria, frequency, or hematuria

Musculoskeletal / Osteopathic Structural Examination:

Denies muscle aches or joint pain

Neurologic:

Denies tremor, weakness, numbness, or tingling