

**Michigan State University – College of Human Medicine
Clinical Skills Oral Case Presentation Protocol**

Oral case presentations vary according to the purpose of the presentation, the audience, the setting and the amount of time allotted. Do not just read a written H&P or SOAP note. Try to include only the information that is relevant to the assessment and plan, realizing that as a preclinical student you may not know what information is most relevant and what information is superfluous. You may leave out subsections that do not contain any information that is relevant to the assessment. However, always present the history, physical examination, diagnostic data if available, assessment, and plan.

This protocol includes the content areas usually included in an oral case presentation for a patient who is newly admitted to the hospital or seen for the first time in the office. Case presentations on rounds in the hospital would generally be much shorter and include a brief summary of the patient's history followed by new information obtained in the last 24 hours. For further guidance and examples, refer to: *Smith*, pp. 227-233 and *A Practical Guide to Clinical Medicine*, at <http://meded.ucsd.edu/clinicalmed/oral.htm>

1. **Introduction:** The introduction sets the stage by briefly summarizing:
 - i. Who the patient is (age, gender, sometimes major diseases or occupation)
 - ii. Why they came in (the chief complaint and/or other health issues addressed at the visit)
 - iii. Brief time course (using either date of onset or days prior to presentation)
 - iv. Source of the history and reliability (only included if unable to obtain adequate history from the patient)

Here are a few examples:

- i. "Mrs. Oliver is a 48 year old woman who was well until July 2 when she developed fatigue, diarrhea, and headache. The source of the history is the patient, whose reliability is questionable due to some confusion, and old hospital records."
- ii. "Mr. Witherspoon is a 69 year old man with severe brittle type II Diabetes Mellitus who presented to the emergency department complaining of approximately 12 hours of confusion. The source of the history is the patient's niece, who is with him, and old hospital records."

2. History of Present Illness (HPI)
 - A. Describe the chronological account of events since the onset of the problem. Provide significant details of symptoms, including symptom dimensions (PPQRST) as appropriate.
 - B. Include pertinent positives and negatives only. This may include information from any portion of the history, i.e., past medical or surgical history, medications, allergies, family or social history, and review of systems, that may relate to the specific diagnostic hypotheses you are considering.
3. Past Medical History (PMH)
 - A. Chronic Diseases
 - B. Significant medical illnesses
 - C. Hospitalizations
 - D. Surgeries
 - E. Health Maintenance
4. Medications
5. Allergies
6. Social History (SOCIAL HX)
7. Family History (FAM HX)
8. Review of Systems (ROS)
9. Physical Examination
 - A. General appearance
 - B. Vital signs
 - C. For the rest of the examination, include pertinent positives (abnormal findings) and negatives (normal findings that relate to the differential diagnosis) only.
10. Diagnostic Data (test results, usually laboratory and radiology)
11. Assessment (usually a differential diagnosis, that is, a list of possible diagnoses)
12. Plan