

## Family Medicine Scenarios

### Scenario 1 of 6:

**Reason for Visit:** Follow-up

**HPI:** Patient is an 8- year old boy who has had asthma since the age of 2. He presents to the office for an asthma follow-up visit. He and his father report increasingly frequent cough and shortness of breath for the past 3 months. He was being treated with low-dose inhaled corticosteroid twice daily and albuterol inhalations. His symptoms occur daily, they get worse when he plays soccer and they wake him at night three to four times per week.

**Past Medical History:** As above; otherwise negative.

**Social History:** Positive for secondhand tobacco exposure.

**Review of Systems:** As above.

**Physical Exam:** Wheezing noted on lung auscultation. No apparent signs of distress.

**Assessment and Plan:** Moderate persistent asthma - step up treatment to a medium dose inhaled corticosteroid.

**Scenario 2 of 6:**

**Reason for Visit:** Recurrent migraine headaches.

**HPI:** A 34-year-old woman is evaluated in the office for migraine headaches, both with and without aura, since she was 13 years old. She averages three to four attacks each month and headaches are worse with menstruation. Headaches occurring with menstruation are only partially relieved with sumatriptan.

**Past Medical History:** Sumatriptan, orally as directed.

**Review of Systems:** As above.

**Physical Exam:** Unremarkable. No focal neurological deficits. Optic exam is WNL.

**Assessment and Plan:** Menstrual migraine, intractable. Change medication regimen prior to onset of menstrual cycle.

**Scenario 3 of 6:**

**Chief Complaint:** Sore throat

**HPI:** The patient is a 18-year-old man being evaluated for a 3-day history of sore throat, cough, fever, and chills.

**Past Medical History:** None.

**Review of Systems:** As above.

**Physical Exam:** Temp.= 102. Patient appears ill. Pharynx is red, tonsils are enlarged with extensive yellow exudate. Positive cervical adenopathy bilaterally. Lungs are clear.

RSA is positive.

**Assessment and Plan:** Strep pharyngitis - start antibiotics.

**Scenario 4 of 6:**

**Chief Complaint:** Fever and cough

**HPI:** The patient is a 21-year-old woman being seen for the acute onset of fever, myalgia, arthralgia, and nonproductive cough.

**Past Medical History:** Noncontributory.

**Review of Systems:** As above.

**Physical Exam:** Temp.= 102, RR= 18. A few crackles are heard at the left lung base.

Leukocyte count is 14,000/uL ( $14 \times 10^9$  L). Chest x-ray shows an infiltrate at the left base.

**Assessment and Plan:** Community-acquired pneumonia - start antibiotics.

**Scenario 5 of 6:**

**Reason for Visit:** Establish medical care.

**HPI:** A 59-year-old male presents to the office as a new patient without new complaints. He states he is compliant with medications, diet and blood sugar monitoring. He denies chest pain, polyuria, polydipsia or edema. He is not sure when last labs were done prior to this appointment's pre-visit labs.

**Past Medical History:** Positive for HTN, Diabetes Type 2, on meds.

**Review of Systems:** As above.

**Physical Exam:** Moderately obese middle-aged male in no acute distress. BP= 122/82, P= 68, RR= 12. Cardiovascular, pulmonary and neurologic exams are WNL.

Lab: Total cholesterol= 250, LDL= 160, HDL= 30, TG= 210

**Assessment and Plan:** Hypercholesterolemia, start meds, recheck labs in 3 months.

**Scenario 6 of 6:**

**Chief Complaint:** Asthma in pregnancy

**HPI:** The patient is a 25-year-old woman with history of persistent asthma, who is now 10 weeks pregnant. Asthma is currently well controlled; she is without new complaints, but is concerned about her asthma treatment during pregnancy. Prior to her current asthma regimen, she had frequent exacerbations.

**Past Medical History:** None.

**Review of Systems:** As above.

**Physical Exam:** Unremarkable.

Spirometry is normal.

**Assessment and Plan:** Asthma in pregnancy - continue current regimen and monitor spirometry. Counseled patient regarding affects of asthma on pregnancy.